SUA Resource Library:

State Caregiver 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 Caregiver Assessments

Division of Services for Aging and Adults with Physical Disabilities

CAREDelaware
Caregiver Assistance-Respite-Education

CareGIVER Assessment

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

Name of Care Recipient: _____ **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:** _____

Caregiver'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

CareGIVER's Date of Birth:

_____

Required for Federal Reporting
☐ **Not reported**

If DOB is unable to be collected, please check appropriate date range:

☐ <50 ☐ 55-59 ☐ 75-84
☐ 50-54 ☐ 60-74 ☐ 85+

Caregiver's relationship to care recipient:

☐ Husband ☐ Wife
☐ Son/Son-in-Law
☐ Daughter/Daughter-in-Law
☐ Other Relative
☐ Non-Relative
☐ *Relationship Not Reported*

Are you the PRINCIPAL CAREGIVER? ☐ Yes ☐ No

Does the care recipient live with you? ☐ Yes ☐ No

Do you also care for children under 18 living at home? ☐ Yes ☐ No

What is your employment status? ☐ Employed Full-Time ☐ Employed Part-Time ☐ Not Employed

On average, how many weekly hours of care do you provide? ☐ Less than 10 ☐ 11 to 20 ☐ 21 to 30 ☐ 30+

Identify support services recommended to this CAREGIVER:

☐ Caregiver Skills Training ☐ Adult Day Care ☐ In-Home Respite ☐ ERS service
☐ Counseling ☐ Legal Assistance ☐ Home Modification ☐ Assistive Technology
☐ Support Group ☐ Caregiver Resource Center
☐ Transportation ☐ Other : _____

CAREGIVER was given to following information / publications:

☐ CARE DE Brochures ☐ Comfort of Home ☐ DSAAPD Guide to Services
☐ Other : _____

Notes: _____

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

DC OFFICE ON AGING

CAREGIVER ASSESSMENT- REASSESSMENT
Primary Caregiver Profile

Date: _____ Caregiver for how long? _____

Social Security #_____ Date of Birth :_____

CG I.D. No._____ Referral Source_____

Caregiver Name: _____, _____, _____
(last) (first) (mi.)

Address & Zip: _____

Daytime Phone: _____ Evening Phone_____

Emergency Contact for Caregiver: _____

Your relationship to Care Receiver:
[ ] spouse [ ] sibling [ ] child [ ] friend/neighbor [ ] step child [ ] other _____

Do you consider your caregiving responsibilities to be?
[ ] 24 hours [ ] full time [ ] part time [ ] occasional

ADL and IADL needs that you or others provide to the care receiver:

Task	No help	Super-vise	Assist	Total Care	Task	No help	Super-vise	Assist	Total Care
Bathing					Shopping				
Grooming					Cleaning				
Eating					Trans-portation				
Toileting					Yard Work				
Mobility					Bill Paying				
Walking					Heavy Cleaning				
Transfer-ring					Medications Management				
Dressing					Use of Telephone				
Therapy/ Exercise					Escort				
Meals					Medical Appts				
Laundry					Coordinate Services				

Do you also provide care for someone else? [ ] Yes [ ] No
If yes, describe your other caregiving responsibility_____

What is your employment status?

[ ] full time	[ ] leave of absence
[ ] part time	[ ] retired
[ ] short term disability	[ ] unemployed
[ ] long term disability	[ ] not able to work due to care for CR

Informal Support

How would you describe your social support system? (READ LIST - check ONE that best describes)

[ ] excellent, includes willing family members and friends
[ ] good, includes family members and friends
[ ] fair, minimal support from family or friends
[ ] poor, no willing family members or friends

Who helps you provide care?

Name	Relationship to Caregiver	Assistance Provided

Are there others who could assist you (family, friends, neighbors, club members, volunteers from a religious institution) [ ] Yes[ ] No

List other potential caregivers:

_____
_____
_____

Living Arrangements

Caregiver's living arrangement/setting:

[ ] lives with Care Receiver in Washington, DC
[ ] lives in Washington, DC apart from Care Receiver distance between homes:_____
[ ] drive [ ] walk [ ] public transportation [ ] other_____

Who are the members of your household?

Name	Age	Gender	Relationship

Health/Mental Health

Would you describe your health as:
[ ] excellent [ ] good [ ] fair [ ] poor

Do you have any medical conditions or physical limitations? [ ] Yes [ ] No (LIST ALL)

How do you describe your emotional health?
[ ] excellent [ ] good [ ] fair [ ] poor

Recently, have you experienced any changes in your physical or emotional health?
[ ] Yes [ ] No If yes, describe:
_____
_____

What concerns, if any, do you have about your physical or emotional health?
_____
_____

Stress

Are you currently experiencing stress because of your caregiving role [ ] Yes [ ] No
If yes, what exactly about your caregiving responsibilities is stressful?

Caregiver self-report stress level: (circle which applies)

0 1 2 3 4 5 6 7 8 9 10

no stress maximum stress
(I can't continue giving care)

What is the most stressful aspect of caregiving for you?

Are you experiencing stress in other areas of your life related to: (READ LIST, Mark ALL that apply)

[ ] children [ ] work [ ] marriage
[ ] personal health concerns [ ] legal arrangements regarding care receiver (power of
[ ] family attorney, advice directives, wills)
[ ] other: _____

Coping

Describe your social outlets, leisure activities, and civic and religious involvement (and how often these occur):

How do you manage all your responsibilities?

What is working well in your caregiving situation?

One important lesson you have learned and can recommend to other caregivers?

Resource Utilization

Have you used community resources to help YOU? [ ] Yes [ ] No (If no, skip next question)

What are the community resources you currently use?
[ ] Homecare [ ] adult daycare [ ] Caregiver educational program
[ ] Written resource materials [ ] other_____
[ ] Respite care – Name of Provider _____
[ ] Caregiver support group -Name of sponsor _____

Why haven't you used community resources for caregivers?
[ ] Did not know about them [ ] Do not have the time [ ]Other_____
[ ] Financial barriers [ ] Transportation barriers

CARE RECEIVER INFORMATION

The following questions are about your older relative/friend:

Care Receiver Name: _____, _____, _____
(last) (first) (mi.)
Address: _____, Zip Code _____

Ward_____ Phone: _____ Date of Birth _____

Care Receiver's Gross monthly income: $_____ Source: _____

Insurance:_____

Health/Mental Health Inventory

Description of care receiver's current health status, illnesses and disabilities:

Alert:[ ]Yes [ ]No Oriented to: [ ]Person [ ]Place [ ]Time Ambulatory: [ ]Yes [ ]No
Incontinence: [ ]Bowel [ ]Bladder

Can be left alone Yes No Comment:_____

Description of care receiver's emotional health:

What health issue causes you the greatest concern and why?

Resource Utilization

What community resources does the older person use and how often?

Service	Provider	Frequency

Does the older person resist using services? [ ] No [ ] Yes, _____

Are there services, supplies or equipment you need for caregiving that you can not afford at this time?
[ ] Yes [ ] No

If yes, List below:

_____
_____

Other Comments/issues of concern/recommendations not addressed elsewhere in this assessment:

_____
_____

Caregiver Support Plan

Caregiver Name _____ CG I.D. #_____
Date_____

A. Self Care and Stress Management Recommendations (Mark ALL that apply)
[ ] 1 Participate in a caregivers' support group
[ ] 2 Attend educational seminars
[ ] 3 Use respite care
[ ] 4 Get physical exam
[ ] 5 Start a fitness program (what type) _____
[ ] 6 Participate in a hobby
[ ] 7 Learn and practice stress reduction techniques (how) _____
[ ] 9 Let others help you

B. Informal Support Plan
For each recommendation checked in Section A, outline the way in which the recommendation can be implemented. Be specific, listing the names and phone numbers of **services** to be accessed (support groups, daycare programs, etc.) and identifying family members and friends who can provide **informal support** and the type of support needed.

Service	**Agency**	**Tel. #**

Informal Support – Describe how family members and friends will be involved in caregiving (i.e., the name of the person, what assistance is needed, how to approach the person to obtain assistance, etc.)

_____
_____
_____
_____

I understand the elements of this support plan and am willing to implement the plan.

_____ _____
Caregiver Signature and Date Assessor Signature and Date

Post visit comments

Rate the potential for Caregiver/situation to deteriorate in the next 12 months

0 1 2 3 4 5 6 7 8 9 10

will stay the same — Moderate potential for decline — High potential for situation to collapse

Do you think the Care Receiver will use the services recommended today?

[ ] Yes [ ] No

[ ] Yes, under the following conditions_____

_____

Do you think the Care Giver will follow through with services recommended today?

[ ] Yes [ ] No

[ ] Yes, under the following conditions_____

_____

CASE MANAGER: **ASSESSMENT DATE:**

D.C. OFFICE ON AGING
CAREGIVER ASSESSMENT

CAREGIVER PROFILE **· New Client · Reassessment**

Social Security #._____ Date of Birth_____

Referral Source_____

Caregiver Name: _____, _____, _____
(last) (first) (mi.)
Address: _____ Zip Code_____

Phone: Day _____Evening_____ Caregiver for how long?_____

Emergency Contact for Caregiver: _____

Your Relationship to Care Receiver:
· spouse · child · step child Ø friend/neighbor Ø sibling Ø other _____

Do you consider your caregiving responsibilities to be?
Ø 24 hours Ø full-time Ø part-time Ø occasional

ADL/IADL assistance that you or others provide to the care receiver:

Task	No Help	Super-vise	Assist	Total Care	Task	No Help	Super-vise	Assist	Total Care
Bathing					Shopping				
Grooming					Cleaning				
Eating					Transpor-ting				
Toileting					Yard Work				
Mobility					Bill Paying				
Walking					Heavy Cleaning				
Trans-ferring					Medication Mgmt				
Dressing					Use of Telephone				
Therapy/ Exercise					Escort				
Meals					Medical Apptmts				
Laundry					Coordin-ate Serv				

Do you also provide care for someone else? Ø Yes Ø No

If yes, describe your other caregiving responsibility _____

What is your employment status?

- ☐ full-time
- ☐ part-time
- ☐ short-term disability
- ☐ long-term disability
- ☐ leave of absence
- ☐ retired
- ☐ unemployed
- ☐ not able to work due to care for CR

Informal Support

How would you describe your social support system? (READ LIST - check ONE that best describes)

- ☐ excellent, includes willing family members and friends
- ☐ good, includes family members and friends
- ☐ fair, minimal support from family or friends
- ☐ poor, no willing family members or friends

Who helps you provide care?

Name	Relationship to Caregiver	Assistance Provided

Are there others who could assist you (family, friends, neighbors, club members, volunteers from a religious institution) ☐ Yes ☐ No

List other potential caregivers:

_____

_____

Living Arrangements

Caregiver's living arrangement/setting:

☐ lives with Care Receiver in Washington, DC

☐ lives in Washington, DC apart from Care Receiver

distance between homes: _____

☐ drive ☐ walk ☐ public transportation ☐ other_____

Who are the members of your household?

Name	Age	Gender	Relationship

Health/Mental Health

Would you describe your health as:
☐ excellent ☐ good ☐ fair ☐ poor

Do you have any medical conditions or physical limitations? ☐ Yes (LIST ALL) ☐ No

_____ _____

_____ _____

_____ _____

How do you describe your emotional health?
☐ excellent ☐ good ☐ fair ☐ poor

Recently, have you experienced any changes in your physical or emotional health?
☐ Yes ☐ No

If yes, describe:

_____

_____

What concerns, if any, do you have about your physical or emotional health?

_____

_____

Stress

Are you currently experiencing stress because of your caregiving role ☐ Yes ☐ No
If yes, what exactly about your caregiving responsibilities is stressful?

_____

_____

Caregiver self-report stress level: (circle which applies)

0 1 2 3 4 5 6 7 8 9 10
no stress — maximum stress (I can't continue giving care)

What is the most stressful aspect of caregiving for you?

_____

_____

_____

Are you experiencing stress in other areas of your life such as: (READ LIST, Mark ALL that apply)

- ☐ children
- ☐ marriage
- ☐ family
- ☐ personal health concerns
- ☐ work
- ☐ legal arrangements regarding care receiver (i.e., power of attorney, advance directives, wills)
- ☐ other _____

Coping

Describe your social outlets, leisure activities, and civic and religious involvement (and how often these occur): _____

_____

_____

How do you manage all your responsibilities? _____

_____

_____

What is working well in your caregiving situation? _____

_____

_____

One important lesson you have learned and can recommend to other Caregivers?

_____

Resource Utilization

Have you used community resources to help **YOU**? ☐ Yes ☐ No (Skip next Q.)

What are the community resources you currently use?
Ø Caregiver support group
Name of Support Group Sponsor_____
Ø Caregiver educational program
Ø Respite care (i.e., day care, home care)
Service/Provider_____
Ø Caregiver Institute
Ø Written resource materials
Ø Other_____

Why haven't you used community resources for caregivers?
Ø Did not know about them
Ø Do not have the time
Ø Financial barriers
Ø Transportation barriers
Ø Other_____

CARE RECEIVER INFORMATION

The following questions are about your older relative/friend:

Care Receiver Name: _____, _____, _____
(last) (first) (mi.)
Address: _____, Zip Code _____

Ward_____ Phone: _____ Date of Birth_____

Care Receiver's Gross monthly income: $_____ Source_____

Insurance _____

Health/Mental Health Inventory

Description of care receiver's current health status, illnesses and disabilities:

ALERT Ø Yes Ø No
ORIENTED Ø Person Ø Place Ø Time
AMBULATORY Ø Yes Ø No

CAN BE LEFT ALONE Ø Yes Ø No
INCONTINENCE Ø Bladder Ø Bowel

Comments:

Description of care receiver's emotional health:

_____

What health issues cause you the greatest concern and why?

_____

_____

Resource Utilization

What community resources does the older person use and how often?

Service	**Provider**	**Frequency**

Does the older person resist using services? ☐ Yes ☐ No

If yes, why? _____

_____

_____

Are there services, supplies or equipment you need for yourself or the older person that you cannot afford at this time? ☐ Yes ☐ No If yes, list below:

Other Comments/issues of concern/recommendations not addressed elsewhere in this assessment:

_____

CAREGIVER SUPPORT PLAN

A. Self Care and Stress Management Recommendations (Mark ALL that apply)

☙ 1 Attend caregiving support group

☐ 2 Attend educational seminars
☐ 3 Use respite care
☐ 4 Get physical exam
☐ 5 Start a fitness program
☐ 6 Participate in a hobby
☐ 7 Attend counseling
☐ 8 Learn and practice stress reduction techniques
☐ 9 Let others help you

B. Support Plan

For each recommendation checked in Section A, outline the way in which the recommendation can be implemented. Be specific, listing the names and phone numbers of **services** to be accessed (support groups, day care programs, etc.) and identifying family members and friends who can provide **informal support** and the type of support needed.

Services	**Agency**	**Tel. #**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Informal Support – Describe how family members and friends will be involved in caregiving (i.e., the name of the person, what assistance is needed, how to approach the person to obtain assistance, etc.)

_____

_____

_____

_____

_____

POST VISIT COMMENTS

Rate the potential for the Caregiver situation to deteriorate in the next 12 months

0 1 2 3 4 5 6 7 8 9 10

Will stay the same — Moderate potential for decline — Higher potential for situation to collapse

Do you think the **Care Receiver** will follow through with services recommended today?

- Yes
- Yes, under the following conditions _____

_____

- No

Do you think the **Caregiver** will follow through with services recommended today?

- Yes
- Yes, under the following conditions _____

_____

- No

OoA Caregiver Assessment Form 12-15-04

KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES
III-E CAREGIVER ASSESSMENT PLAN **KAMIS ID #** _____

I. INTAKE
Interviewer _____ PSA _____ Date of Assessment _____ ☐ Initial ☐ Reassessment

II. CAREGIVER CATEGORY
☐ Caregiver (Complete Sec. III, V, VI, and VII)
☐ Grandparent: ☐ Caring for child(ren) < 19 years of age (Complete Sec. III, IV, and VII)
☐ Caring for disabled adult(s) 19-59 years of age (Complete Sec. III, IV, VI, and VII)

III. CAREGIVER INFORMATION
☐ Male ☐ Female
Name (First, Middle, Last) _____ DOB _____ SSN _____
Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino
Race: ☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic ☐ Native Hawaiian/Pacific Islander ☐ Reporting 2 or more races ☐ Reporting other race ☐ White/Non-Hispanic
Address _____ City _____ County _____ State _____ Zip Code _____
☐ Urban ☐ Rural
Home Phone _____ Work Phone _____ Cell Phone _____

IV. CAREGIVER for Child(ren) or Disabled Adult(s):
Number of children cared for: Number of disabled adults cared for:
Relationship to Child(ren)/Disabled Adult(s) ☐ Grandparent ☐ Elderly Relative ☐ Elderly Non-relative

V. CAREGIVER for Adult - Relationship to Recipient ☐ Husband ☐ Wife
☐ Daughter/Daughter-in-law ☐ Son/Son-in-law ☐ Other Relative ☐ Non-relative

VI. ADULT CARE RECIPIENT #1 INFORMATION:
Qualifying Care Recipient: ☐ Senior 60 years or older ☐ Adult w/Alzheimer's <60 ☐ Disabled Adult 19-59
☐ Male ☐ Female
Name (First, Middle, Last) _____ DOB _____ Recipient SSN _____
Address _____ City _____ County _____ State _____ Zip Code _____
☐ Urban ☐ Rural
Home Phone _____ Work Phone _____ Cell Phone _____

ADLS
☐ Bathing ☐ Dressing ☐ Toileting ☐ Transfer ☐ Walking/Mobility ☐ Eating

IADLS
☐ Meal Preparation ☐ Shopping ☐ Money Management ☐ Transportation ☐ Use of Telephone ☐ Laundry/Housekeeping ☐ Medication Mgmt/Treatment

VII. CAREGIVER SERVICE PLAN

Recipient No.	Service Code	Provider Name	Units	Per	Total Units	Start Date	End Date	Discharge Code

VIII. ADULT CARE RECIPIENT #2:

CAREGIVER for Adult - Relationship to Recipient: ☐ Husband ☐ Wife
☐ Daughter/Daughter-in-law ☐ Son/Son-in-law ☐ Other Relative ☐ Non-relative

Qualifying Care Recipient: ☐ Senior 60 years or older ☐ Adult w/Alzheimer's <60 ☐ Disabled Adult < 60

ADULT CARE RECIPIENT #2 INFORMATION ☐ Male ☐ Female

Name (First, Middle, Last _____ DOB _____ Recipient SSN _____

Address _____ City _____ County _____ State _____ Zip Code _____

☐ Urban ☐ Rural

Home Phone _____ Work Phone _____ Cell Phone _____

ADLS
☐ Bathing ☐ Walking/Mobility
☐ Dressing ☐ Eating
☐ Toileting
☐ Transfer

IADLS
☐ Meal Preparation ☐ Use of Telephone
☐ Shopping ☐ Laundry/Housekeeping
☐ Money Management ☐ Medication Mgmt/Treatment
☐ Transportation

IX. ADULT CARE RECIPIENT #3:

CAREGIVER for Adult - Relationship to Recipient: ☐ Husband ☐ Wife
☐ Daughter/Daughter-in-law ☐ Son/Son-in-law ☐ Other Relative ☐ Non-relative

Qualifying Care Recipient: ☐ Senior 60 years or older ☐ Adult w/Alzheimer's <60 ☐ Disabled Adult < 60

ADULT CARE RECIPIENT #3 INFORMATION ☐ Male ☐ Female

Name (First, Middle, Last _____ DOB _____ Recipient SSN _____

Address _____ City _____ County _____ State _____ Zip Code _____

☐ Urban ☐ Rural

Home Phone _____ Work Phone _____ Cell Phone _____

ADLS
☐ Bathing ☐ Walking/Mobility
☐ Dressing ☐ Eating
☐ Toileting
☐ Transfer

IADLS
☐ Meal Preparation ☐ Use of Telephone
☐ Shopping ☐ Laundry/Housekeeping
☐ Money Management ☐ Medication Mgmt/Treatment
☐ Transportation

X. NOTES:

_____

_____

_____

_____

_____

_____

III-E CAREGIVER ASSESSMENT PLAN
INSTRUCTIONS

GENERAL

- Do not use this form if you are providing "**Information**" or **"Assistance"** only.
- Complete the entire III-E Caregiver Assessment Plan (CAP) according to the instructions provided below when requesting or providing the following Title III-E Services: Individual Counseling; Support Group; Caregiver Training (Individual or Group); Respite; and Supplemental Services.

SECTION I: INTAKE

- Complete ***all*** information in Section I.

SECTION II: CAREGIVER CATEGORY

- Check the funding category for which the applicant is applying. If applying for more than one category, separate forms must be completed.
- Check "Grandparent" if caring for Child/Children < 19 years of age or disabled adult(s) 19 - 59 years of age, regardless of the caregiver's relationship to the child or disabled adult.

SECTION III: CAREGIVER INFORMATION

- Complete ***all*** "Caregiver" information, including a complete address and Urban/Rural designation.
- The Ethnicity and Race categories reflect Office of Management and Budget (OMB) requirements. Caregivers are to be asked about their ethnicity and race as two separate questions. The Caregiver should be given the opportunity for self-identification, and allowed to designate all categories that apply to them. The Ethnicity and Race categories will be used for data collection purposes only.

SECTION IV: CAREGIVER FOR CHILD/CHILDREN <19 YEARS OF AGE OR DISABLED ADULT 19-59 YEARS OF AGE

- Complete this section only if "Grandparent" Caregiver Category checked.
- List the total number of qualifying children and total number of qualifying disabled adults being care for in the home. Check all applicable "Relationships" to the child(ren) and disabled adult(s).

SECTION V: CAREGIVER FOR ADULT

- Check the applicable "Relationship". A separate section for each adult care recipient is required.

SECTION VI: ADULT CARE RECIPIENT #1 INFORMATION:

- Complete ***all*** "Adult Care Recipient #1" information.

SECTION VII: CAREGIVER SERVICE PLAN

- Enter Care Recipient No. (e.g. Recipient #1, 2, or 3) for applicable adult or leave column blank if "Grandparent caring for grandchild(ren) < 19 years of age" Caregiver;
- Enter Service Code; Provider Name; Units; Per (day or week); Total Units (per month); Service Start Date; and Service End Date.
- Enter a Discharge Code when the Caregiver no longer receives a service.

SECTION VIII: ADULT CARE RECIPIENT #2

- Complete ***all*** "Adult Care Recipient" information for a second adult if two or more adults are care recipients.

SECTION IX: ADULT CARE RECIPIENT #3

- Complete ***all*** "Adult Care Recipient" information for a third adult if three or more adults are care recipients. **(***Additional forms may be used if more than three adults are care recipients.)*

SECTION X: NOTES

- This section is available for the Interviewer to record any information that may be applicable.

Contact the KDADS Family Caregiver Support Program Manager at 1-800-432-3535 if you have questions regarding this form.

KAMIS DATA ENTRY REQUIREMENTS

The III-E Caregiver Assessment Plan (CAP) (SS-025) must be entered into KAMIS before the 20th day of the month following the month in which services were provided. The Caregiver Service Plan's Start Date entered into KAMIS allows Caregiver Service providers to be reimbursed effective with this date of service. In addition, the AAA must verify the Group I Services provided and submit through the KAMIS 225 process before the 20th day of the month following the month in which services were provided.

Following is a list of required KAMIS fields:

SECTION I INTAKE:
Interviewer, PSA, Date of Assessment, Initial or Reassessment designation

SECTION II CAREGIVER CATEGORY:
Caregiver or Grandparent
If Grandparent, select caring for grandchild(ren) < 19 years of age or caring for disabled adult(s) 19 - 59 years of age, or both if applicable

SECTION III CAREGIVER INFORMATION:
The following caregiver information must be entered:
Name, date of birth, gender, ethnicity, race, city, county, state, urban/rural designation

SECTION IV GRANDPARENT CAREGIVER CATEGORY (Required if "Grandparent" funding checked in Section II):
Number of children and number of disabled adults, if applicable
Relationship to child/children and disabled adult(s), if applicable

SECTION V CAREGIVER for ADULT
Relationship to Recipient

SECTION VI ADULT CARE RECIPIENT #1 (Required if "Caregiver" funding checked in Section II):
Qualifying Care Recipient

SECTION VII CAREGIVER SERVICE PLAN
The following information must be entered to initiate services:
Recipient No., Service Code, Provider Name, Units, Per, Total Units, Start Date, End Date
(Note: The End Date shall be the date the service is to terminate or one year from the Start Date, whichever comes first.)
Discharge Code shall be entered when the service is terminated.

SECTION VIII ADULT CARE RECIPIENT #2 (Complete if more than one adult is a care recipient):
Relationship to Recipient
Qualifying Care Recipient

SECTION IX ADULT CARE RECIPIENT #3 (Complete if more than two adults are care recipients):
Relationship to Recipient
Qualifying Care Recipient

SECTION X NOTES:
None

INSTRUCTIONS FOR COMPLETING NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM INTAKE FORM

The initial intake can be taken in person or over the telephone. Explain to Caregiver (Client) that all information provided will be kept confidential. Conduct intake in a secure setting where privacy can be protected.

1. **Section A: Agency/Organization Information**
   Enter Date of Request/Referral, Method of Contact, Assessor Name, Agency Name
2. **Section B: Initial Screening and Intake**
   Choose appropriate category for Client status. If client is a Family Caregiver, enter the relationship to the Qualifying Individual.
3. Obtain and record qualifying individual's identifying information.
4. **Section C: Caregiver Information**
   Obtain and record Client identifying information. Explain that this will be used to establish an Identification Number that can be used to keep report the services the Client receives to the funding source. Enter the last four digits of the Caregiver's Social Security Number only. Create the Louisiana Identification Number using his/her date of birth and the last four digits of SSN (e.g., Client born June 20, 1926 = ID# 062019268333)
5. **Section D: Determine Client eligibility for priority status**. Check Appropriate box. Greatest Economic Need, Greatest Social Need, and individual providing care for person who has developmental disability are determined based upon self-reported data.

   a. Greatest Economic Need- Ask for the number of persons in the Client's household. Then check the chart below and ask whether the annual income more or less than the amount in the corresponding column.

2015 HHS Poverty Guidelines[1]

Size of Family Unit	48 Contiguous States & D.C.
1	$ 11,770
2	$15,930
3	$20,090
4	$24,250
5	$28,410
6	$32,570
7	$36,730
8	$40,890

[1] **SOURCE**: *Federal Register*, Vol. 79, No. 14, January, 22, 2014, pp. 3593-3594

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For each additional person, add	$4,160

b. Greatest Social Need - Determine whether the Client has any of the following problems:
physical and mental disabilities;
language barriers (difficulty understanding or speaking English); or
cultural, social, or geographical isolation, including isolation caused by racial or ethnic status, that - restricts the ability of an individual to perform normal daily tasks; or threatens the capacity of the individual to live independently.

c. Either a letter of Eligibility from the Office of Citizens with Developmental Disabilities (OCDD) or a doctor's statement can be used to verify eligibility for priority status under the National Family Caregiver Support Program due to a developmental disability. If the qualifying individual has not received a letter of Eligibility from OCDD, provide Client a copy of **DOCTOR'S STATEMENT FORM** to be signed and returned before services are authorized. The DOCTOR'S STATEMENT FORM or a copy of the Letter of Eligibility will become a permanent part of Client records.

6. Eligibility for Respite Care, Material Aid, Personal Care and Sitter Service

a. Ask the Client to describe the type of assistance the qualifying individual requires.
b. Ask whether the qualifying individual can be left alone, and if not, why not?
c. Check appropriate box(es).

7. Describe the type of assistance or information requested by the Client.

8. Obtain directions from the area agency on aging to the home of the qualifying individual.

9. If Client needs Respite Care, Material Aid, Personal Care or Sitter Service proceed to step 10. If not, skip to step 12.

10. Complete the Family Caregiver Support Program Score Sheet. Leave item #11 blank until the caregiver stress level is obtained from the Caregiver Stress Interview.

11. Complete the Caregiver Stress Interview. Record the caregiver stress level on the Score Sheet and calculate the Total Score. Record the Total Score on Page 1 of the Intake Form.

12. Explain and provide Client with a copy of the area agency's policy regarding participant contributions and grievance procedure.

13. Have Client sign and date Intake Form.

14. Complete Initial Contact information at the top of the Intake Form. Sign and date form.

15. Clients must be reassessed annually.

Name of Client (Caregiver): ID#:

NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM
INTAKE ASSESSMENT FORM

SECTION A: AGENCY/ORGANIZATION INFORMATION

Date of Request or Referral: _____ **Method of Contact**: ❒telephone ❒ face-to-face
Month/Day/Year ❒other
Assessor Name: _____ **Agency Name: _____**

SECTION B: INITIAL SCREENING AND INTAKE

PERSON PROVIDING ANSWERS AND INFORMATION FOR ASSESSMENT:

❒ Caregiver ❒ Friend/neighbor ❒ Legal guardian or surrogate decision-maker
❒ Family member ❒ Other professional (e.g. care manager)

PRIMARY LANGUAGE:

❒ English ❒ Spanish ❒ French ❒ Other _____

QUALIFYING INDIVIDUAL (Person receiving care):

Name: _____ Address:_____

State: _____ Zip Code: _____ Parish: _____ Phone: _____

Social Security Number: _____ Date of Birth: _____
Caregiver by Relationship ❒ Husband ❒ Wife ❒ Son/Son-in-law ❒ Daughter/Daughter-in-law
❒ Other Relative ❒ Non-Relative

SECTION C: CAREGIVER INFORMATION

Social Security Number: ☐☐☐-☐☐-☐☐☐☐

Louisiana Identification Number: ☐☐☐☐☐☐☐☐☐☐☐☐

Last Name: _____ **First Name**: _____ **MI**: _____

Address:_____ **Apt. #**: _____ **Parish**: _____

State: _____ **Zip Code**: _____ **Telephone (Home)**: _____ **Work**: _____

DOB: _____ **Rural/Isolated**: ❒ Yes ❒ No
Month/Day/Year

Gender: ❒ Male ❒ Female

Race: ❒ White (Alone)
❒ Black or African American (Alone)
❒ American Indian/Alaskan Native (Alone)
❒ Native Hawaiian/Other Pacific Islander
❒ Asian (Alone)
❒ Declined to Respond
❒ Other_____

Marital Status: ❒ Never Married
❒ Married
❒ Partner/Significant Other
❒ Widowed
❒ Separated
❒ Divorced

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Name of Client (Caregiver): ID#:

Ethnicity: ❒Hispanic/Latino ❒Not Hispanic/Latino

NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM
INTAKE ASSESSMENT FORM (CONTINUED)

Name of Client (Caregiver): _____ ID #: _____

SECTION D: Priority Status (check all that apply)
☐ Client is an older individual in greatest economic need
☐ Client is an older individual in greatest social need
☐ Client is an older individual providing care and support to person who has a developmental disability
Eligibility for Respite Care, Personal Care, Material Aid and Sitter Service (check all that apply – at least one must apply to be eligible):
☐ The qualifying individual is unable to perform at least two of the following activities without substantial human assistance, including verbal reminding, physical cueing, or supervision: bathing; dressing; toileting; transferring; walking: eating.
☐ The qualifying individual has a cognitive or other mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or to another individual.
Describe the type of assistance needed {continue on supplemental sheet(s)}:
Directions to Home of Qualifying Individual {continue on supplemental sheet(s)}:

I have received a copy of the grievance procedure and contribution policy.

_____ _____

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Name of Client (Caregiver): ID#:

Date **Signature of Caregiver**

_____ _____

Date **Signature of Intake Worker**

Family Caregiver Support Program Score Sheet

1. The caregiver's income level is at or below the federal poverty line. No = 0 Yes = 1	
2. The caregiver has "greatest social need." No = 0 Yes = 1	
3. The caregiver is 60 years of age or older and providing care and support to person that has a developmental disability. No = 0 Yes = 1	
4. Age of caregiver: Under 60 = 0 60 -74 years of age = 1 75 years of age or older = 2	
5. How does the caregiver rate her/his overall health? Good = 0 Fair = 1 Poor = 2	
6. For how many qualifying individuals is this caregiver the primary caregiver? (One point for each qualifying individual)	
7. How many hours of direct care on average each day does the caregiver provide to the qualifying individual? 8 hours or less = 0 9 - 16 hours= 1 17 - 24 hours = 2	
8. Is the caregiver employed? No = 0 Part-time = 1 Full- time (35 or more hours/week) = 2	
9. With how many of the following activities of daily living does the caregiver provide assistance to the qualifying individual? (one point for each - circle all that apply) BATHING DRESSING TOILETING TRANSFERRING WALKING EATING	
10. Does the qualifying individual receive assistance with any of the activities in question 9 from any other source? Yes = 0 No = 1	
11. Caregiver Stress Level: [2]Little/No Stress = 0 Mild/Moderate = 1 Moderate/Severe Stress = 2 Severe Stress = 3	
TOTAL SCORE	

[2]**From Caregiver Stress Interview**

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Name of Client (Caregiver): ID#:

CAREGIVER STRESS INTERVIEW

Read to Caregiver: The following is a list of statements which reflect how people sometimes feel when taking care of another person. After each statement, indicate how often you feel that way: never, rarely, sometimes, quite frequently, or nearly always. There are no right or wrong answers.

QUESTION	Never (0)	Rarely (1)	Sometimes (2)	Quite Frequently (3)	Nearly Always (4)	Score
1. Do you feel that your relative asks for more help than he/she needs?						
2. Do you feel that because of the time you spend with your relative that you don't have enough time for yourself?						
3. Do you feel stressed between caring for your relative and trying to meet other responsibilities for your family or work?						
4. Do you feel embarrassed over your relative's behavior?						
5. Do you feel angry when you are around your relative?						
6. Do you feel that your relative currently affects your relationship with other family members or friends in a negative way?						
7. Are you afraid of what the future holds for your relative?						
8. Do you feel your relative is dependent upon you?						
9. Do you feel strained when you are around your relative?						
10. Do you feel your health has suffered because of your involvement with your relative?						
11. Do you feel that you don't have as much privacy as you would like because of your						

Name of Client (Caregiver): ID#:

QUESTION	Never (0)	Rarely (1)	Sometimes (2)	Quite Frequently (3)	Nearly Always (4)	Score
relative?						
12. Do you feel that your social life has suffered because you are caring for your relative?						
13. Do you feel uncomfortable about having friends visit you because you are caring for your relative?						
14. Do you feel that your relative seems to expect you to take care of him/her as if you were the only one he/she could depend on?						
15. Do you feel that you don't have enough money to care for your relative in addition to the rest of your expenses?						
16. Do you feel that you will be unable to take care of your relative much longer?						
17. Do you feel you have lost control of your life since your relative's illness?						
18. Do you wish you could just leave the care of your relative to someone else?						
19. Do you feel uncertain about what to do about your relative?						
20. Do you feel you should be doing more for your relative?						
21. Do you feel you could do a better job in caring for your relative?						
22. Overall, do you feel burdened caring for your relative?						
CAREGIVER STRESS LEVEL: [2]						

[2] The caregiver stress level is calculated by summing the scores of the individual items as follows:

0 - 20 = Little/No Stress 21 - 40 = Mild/Moderate Stress
41- 60 = Moderate/Severe Stress; 61 - 88 = Severe Stress

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Name of Client (Caregiver): ID#:

CLIENT SERVICE RECORD

(copy as needed)

Approved Services	Service Provider	Beginning Service Date	Ending Service Date

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Name of Client (Caregiver): ID#:

Approved Services	Service Provider	Beginning Service Date	Ending Service Date

SUPPLEMENTAL SHEET

(copy as needed)

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Name of Client (Caregiver): ID#:

Name of Client (Caregiver): ID#:

NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM

DOCTOR'S STATEMENT FORM

This is to verify that I have personally examined

(Name of Qualifying Individual)

and found him/her to have the following:

A diagnosis of developmental disability.Developmental disabilityrefers to significantly sub-average general intellectual function existing concurrently with deficits in adaptive behavior and manifested prior to age 22; or

A severe, chronic disability which is attributable to developmental disability, cerebral palsy, epilepsy or autism; or any other condition, other than mental illness, found to be closely related to developmental disabilitybecause this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with developmental disabilityor requires treatment of services similar to those required for these persons; the disability:

i. is manifested before the person reaches age 22;

ii. is likely to continue indefinitely;

iii. results in substantial functional limitations in three or more of the following areas of major life activity: self-care; understanding and use of language; learning; mobility; self-direction; capacity for independent living; economic self-sufficiency; and

iv. reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, supports, or other assistance that is of lifelong or extended duration and is individually planned and coordinated; or

Substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disabilities if services described in iv, above, are not provided (applies to individuals from birth to age 5).

Signature Date

FCSP v1.0.1

SECTION I: REFERRAL SOURCE

REFERRAL SOURCE

How did you complete this assessment?

- [ ] In Person
- [ ] Over the Phone

Who referred the caregiver to have a caregiver assessment?

- [ ] Adult Day Health Care Center
- [ ] AFC
- [ ] Caregiver (self-referral)
- [ ] Caregiver Specialist
- [ ] Case Manager
- [ ] COA
- [ ] Family
- [ ] Friend
- [ ] GAFC
- [ ] Health Professional (e.g. Doctor, Hospital, Discharge Planner)
- [ ] Information & Referral
- [ ] Intake Specialist
- [ ] Mental Health Professional
- [ ] Options Counselor
- [ ] Other
- [ ] SCO
- [ ] SHINE
- [ ] VA
- [ ] Visiting Nurses Association (VNA)

If Other, please specify.

_____

SECTION II: CAREGIVER CONTACT INFORMATION AND CAREGIVING SITUATION

CONTACT INFORMATION

What is the caregiver's last name?

_____

What is the caregiver's first name?

_____

Address

_____

City/Town

_____

Enter the caregiver's state of residence.

_____

Zip Code

_____

Home Telephone Number

_____

Cell Phone Number

_____

Work Phone Number

_____

E-mail Address

_____

Does the caregiver live with the care recipient?

- ☐ Same structure/separate living area
- ☐ No
- ☐ Yes

How far away does the caregiver live from the care recipient?

- ☐ Within a 1/2 hour
- ☐ 1/2 hour to hour
- ☐ Over an hour
- ☐ Out of State
- ☐ Out of Country
- ☐ Not applicable

What is the caregiver relationship to care recipient? Please select one.

- ☐ Husband
- ☐ Wife
- ☐ Domestic Partner / Significant Other
- ☐ Same Sex Partner
- ☐ Son/Son-in-Law
- ☐ Daughter/Daughter-in-Law
- ☐ Other Relative
- ☐ Non-Relative
- ☐ Grandparent
- ☐ Other Elderly Relative
- ☐ Other Elderly Non-Relative

What is the caregiver's date of birth?

_____/_____/_____

Caregiver's gender

- ☐ Declined to Disclose
- ☐ Female
- ☐ FTM - Female to Male
- ☐ Male
- ☐ MTF - Male to Female
- ☐ Other
- ☐ Transgendered
- ☐ Unknown

How long has caregiver provided assistance? Please pick one of the answers below using the nearest whole year.

- ☐ Less than 1 year
- ☐ 1 to 2 years
- ☐ 3 to 5 years
- ☐ 6 to 10 years
- ☐ 11 years or longer

How many hours per week does the caregiver spend on caregiving?

- ☐ 1-5 hours
- ☐ 6-10 hours
- ☐ 11-20 hours
- ☐ 21-35 hours
- ☐ 36+ hours
- ☐ 24 X 7

Is the caregiver also a caregiver for another person?

- ☐ No
- ☐ Yes

Who else is the caregiver responsible for? (Check all that apply)

- [ ] Child(ren)
- [ ] Domestic Partner/Significant Other
- [ ] Same Sex Partner
- [ ] Grandchild(ren)
- [ ] Other Family Members
- [ ] Spouse
- [ ] Not Applicable

Do the responsibilities include anyone with special needs/medical conditions/disabled?

- [ ] No
- [ ] Yes
- [ ] Not Applicable

Is the caregiver employed? Please pick one of the answers below.

- [ ] Yes, employed full-time
- [ ] Yes, employed part-time
- [ ] Not working, would like employment
- [ ] Seeking employment
- [ ] No, not employed

What is the caregiver's primary language?

- [ ] English
- [ ] French
- [ ] Spanish
- [ ] Albanian
- [ ] American Sign Language (ASL)
- [ ] Amharic
- [ ] Arabic
- [ ] Armenian
- [ ] Bengali
- [ ] Bosnian
- [ ] Bulgarian
- [ ] Cambodian (Khmer)
- [ ] Cape Verdean Creole
- [ ] Chinese - Cantonese
- [ ] Chinese - Mandarin
- [ ] Chinese - Toisanese
- [ ] Chinese - Other
- [ ] Croatian
- [ ] Dutch
- [ ] Ethiopian
- [ ] Farsi / Iranian / Persian
- [ ] French Creole
- [ ] German
- [ ] Greek
- [ ] Gujarati
- [ ] Haitian Creole
- [ ] Hebrew
- [ ] Hindi
- [ ] Hmong
- [ ] Hungarian
- [ ] Italian
- [ ] Japanese
- [ ] Korean
- [ ] Kutchi
- [ ] Laotian
- [ ] Lithuanian
- [ ] Nepali
- [ ] Polish
- [ ] Portuguese
- [ ] Punjabi
- [ ] Romanian
- [ ] Russian
- [ ] Serbian-Cyrillic
- [ ] Slovenian
- [ ] Somali
- [ ] Swahili
- [ ] Swedish
- [ ] Tagalog
- [ ] Tamil
- [ ] Thai
- [ ] Turkish
- [ ] Urdu
- [ ] Vietnamese
- [ ] Other (specify 'Other' language in Notes field)

SECTION III: CARE RECIPIENT'S CHARACTERISTICS

CARE RECIPIENT'S CHARACTERISTICS

What is the care recipient's first name?

_____

What is the care recipient's last name?

_____

Is the Care Recipient a client of the AAA/ASAP?

- ☐ No
- ☐ On Waitlist
- ☐ Unknown
- ☐ Yes

Which program(s) is the care recipient enrolled in?

- ☐ AFC
- ☐ Community Choices
- ☐ ECOP
- ☐ GAFC
- ☐ Home Care Basic (non-waiver)
- ☐ Home Care Basic (waiver)
- ☐ Napis/Meals
- ☐ PCA
- ☐ Private Pay Care Management
- ☐ Respite Over-Income
- ☐ SCO
- ☐ Not Enrolled in Any Program
- ☐ Unknown to Caregiver
- ☐ Other

How did the caregiver explain the care recipient's present physical/mental health? Check all that apply.

- ☐ Alzheimer's disease
- ☐ Arthritis
- ☐ Cancer
- ☐ Dementia other than Alzheimer's disease
- ☐ Diabetes
- ☐ Fractured bone/osteoporosis
- ☐ Frail
- ☐ Hearing impairment
- ☐ Heart/circulation
- ☐ Infection
- ☐ Mental health concern
- ☐ Neurological Disorder
- ☐ Oral Health
- ☐ Respiratory
- ☐ Visual impairment
- ☐ Other

If Other is checked, how does the caregiver explain the care recipient's present physical/mental health.

_____

_____

_____

_____

Does the care recipient have a health care proxy?

- ☐ No
- ☐ Yes
- ☐ Unknown

A. SUPPORT OTHER THAN ADLS AND IADLS

Who advocates or facilitates participation in health care for the care recipient?

- ☐ Private pay
- ☐ Caregiver
- ☐ Independent
- ☐ Non-paid family, friends and/or volunteers
- ☐ Program Paid
- ☐ Unmet

Environmental support (housing, home maintenance) for the care recipient?

- ☐ Private pay
- ☐ Caregiver
- ☐ Independent
- ☐ Non-paid family, friends and/or volunteers
- ☐ Program Paid
- ☐ Unmet

Who helps the care recipient with legal matters?

- ☐ Private pay
- ☐ Caregiver
- ☐ Independent
- ☐ Non-paid family, friends and/or volunteers
- ☐ Program Paid
- ☐ Unmet

Who is the care recipient's power of attorney / conservator?

- ☐ Private pay
- ☐ Caregiver
- ☐ Independent
- ☐ Non-paid family, friends and/or volunteers
- ☐ Program Paid
- ☐ Unmet

Who helps with the care recipient's psychosocial support?

- [ ] Private pay
- [ ] Caregiver
- [ ] Independent
- [ ] Non-paid family, friends and/or volunteers
- [ ] Program Paid
- [ ] Unmet

B: HELP WITH ACTIVITIES OF DAILY LIVING

Who helps with bathing?

- [ ] Private pay
- [ ] Caregiver
- [ ] Independent
- [ ] Non-paid family, friends and/or volunteers
- [ ] Program Paid
- [ ] Unmet

Who helps with dressing?

- [ ] Private pay
- [ ] Caregiver
- [ ] Independent
- [ ] Non-paid family, friends and/or volunteers
- [ ] Program Paid
- [ ] Unmet

Who helps with eating?

- [ ] Private pay
- [ ] Caregiver
- [ ] Independent
- [ ] Non-paid family, friends and/or volunteers
- [ ] Program Paid
- [ ] Unmet

Who helps with personal hygiene?

- [ ] Private pay
- [ ] Caregiver
- [ ] Independent
- [ ] Non-paid family, friends and/or volunteers
- [ ] Program Paid
- [ ] Unmet

Who helps with toileting?

- [ ] Private pay
- [ ] Caregiver
- [ ] Independent
- [ ] Non-paid family, friends and/or volunteers
- [ ] Program Paid
- [ ] Unmet

C: HELP WITH INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Who helps with Heavy Housework?

- [ ] Private pay
- [ ] Caregiver
- [ ] Independent
- [ ] Non-paid family, friends and/or volunteers
- [ ] Program Paid
- [ ] Unmet

Who provides assistance with laundry?

- [ ] Private pay
- [ ] Caregiver
- [ ] Independent
- [ ] Non-paid family, friends and/or volunteers
- [ ] Program Paid
- [ ] Unmet

Who helps with managing finances?

- [ ] Private pay
- [ ] Caregiver
- [ ] Independent
- [ ] Non-paid family, friends and/or volunteers
- [ ] Program Paid
- [ ] Unmet

Who helps with medication management?

- [ ] Private pay
- [ ] Caregiver
- [ ] Independent
- [ ] Non-paid family, friends and/or volunteers
- [ ] Program Paid
- [ ] Unmet

Who helps with mobility?

- [ ] Private pay
- [ ] Caregiver
- [ ] Independent
- [ ] Non-paid family, friends and/or volunteers
- [ ] Program Paid
- [ ] Unmet

Who helps with using the phone?

- [ ] Private pay
- [ ] Caregiver
- [ ] Independent
- [ ] Non-paid family, friends and/or volunteers
- [ ] Program Paid
- [ ] Unmet

Who helps with meal preparation?

- ☐ Private pay
- ☐ Caregiver
- ☐ Independent
- ☐ Non-paid family, friends and/or volunteers
- ☐ Program Paid
- ☐ Unmet

Who helps with shopping?

- ☐ Private pay
- ☐ Caregiver
- ☐ Independent
- ☐ Non-paid family, friends and/or volunteers
- ☐ Program Paid
- ☐ Unmet

Who provides transportation to activities?

- ☐ Private pay
- ☐ Caregiver
- ☐ Independent
- ☐ Non-paid family, friends and/or volunteers
- ☐ Program Paid
- ☐ Unmet

SECTION IV: CAREGIVER SERVICE ASSESSMENT

A. CAREGIVER'S NEEDS

What are the caregiver's immediate needs/concerns that prompted this assessment? Check all that apply.

- ☐ Accessing services for the care recipient.
- ☐ Addressing personal concerns other than caregiver responsibilities.
- ☐ Balancing work and caregiving responsibilities.
- ☐ Dealing with own physical health.
- ☐ Financial strain/constraints.
- ☐ Home modification.
- ☐ Immediate care of care recipient.
- ☐ Managing other family responsibilities.
- ☐ Managing the care recipient's medications.
- ☐ Other
- ☐ Respite
- ☐ Safety issue/care recipient at risk of falling or left unsupervised.
- ☐ Understanding and managing the care recipient's health needs.
- ☐ Understanding and managing the behavior of the care recipient.

Does the caregiver wish to continue her/his caregiving role? If No or Unknown, please make comments in the Notes section.

- ☐ No
- ☐ Unknown
- ☐ Unsure
- ☐ Yes

Does the caregiver feel s/he has the necessary ability and knowledge to care for the care recipient? If No or Unknown, please make comments in the Notes section.

- ☐ No
- ☐ Unknown
- ☐ Unsure
- ☐ Yes

What caregiver support system(s) does the caregiver rely on? Check all that apply.

- ☐ Community Resources
- ☐ Faith Community
- ☐ Counseling
- ☐ Family
- ☐ Support Groups
- ☐ Neighbors/Friends

Does the caregiver have a back-up plan for her/himself in the event s/he unexpectedly could not assist the care recipient?

- ☐ No
- ☐ Yes

If the caregiver has a back-up plan, is it adequate?

- ☐ No
- ☐ Yes
- ☐ Not Applicable

If caregiver doesn't have back-up plan, would they like to develop one?

- ☐ No
- ☐ Yes
- ☐ Not Applicable

B. CAREGIVER'S PERSONAL HEALTH AND WELL-BEING

How does the caregiver rate his/her health?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Unknown

Is this a change from 3 months ago?

- ☐ No
- ☐ Unknown
- ☐ Yes, Deteriorated
- ☐ Yes, Improved
- ☐ Not Applicable

How does the caregiver rate her/his emotional health at the present time?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Unknown

Is this a change from 3 months ago?

- ☐ No
- ☐ Unknown
- ☐ Yes, deteriorated
- ☐ Yes, improved

When providing care to the care recipient, what situations are stressful for the caregiver? Check all that apply from the list below and use "other" for additional situations. When the care recipient...

- [ ] Gets up at night (often)
- [ ] Has bowel or bladder "accident"
- [ ] Has unexpected health or behavior changes
- [ ] Is left alone -- possible safety issues
- [ ] Is threatening to others (verbal or physical)
- [ ] Is uncooperative (e.g. refuses to take medications)
- [ ] Is unwilling to accept assistance/services from others
- [ ] Repeats questions/stories
- [ ] Requires care causing the CG time away from spouse, children and/or family.
- [ ] Requires care causing the CG to miss work, leave early, reduce hours
- [ ] Requires care that causes changes in personal plan& decline in social activities
- [ ] Is at risk of falling/falls often
- [ ] Financial problems
- [ ] Not understanding how to care for client
- [ ] Is restless or agitated
- [ ] Wanders
- [ ] Other

Does the caregiver have a self-care plan that includes stress reduction for herself/himself?

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

Does the plan include any of the following options? (Check all that are known.)

- [ ] Ensuring leisure time
- [ ] Exercise/Sports
- [ ] Hobbies
- [ ] Keeping appointments (i.e. medical / counseling)
- [ ] Meditation
- [ ] Social Activities
- [ ] Spirituality
- [ ] Support Group
- [ ] Other

Does the caregiver believe s/he is spending enough time and attention to her/his own well-being?

- [ ] Most of the time
- [ ] Seldom
- [ ] Never
- [ ] Unknown

Does the caregiver feel a sense of satisfaction or other positive feelings helping the care recipient?

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

What services and support options were discussed with the caregiver to meet his/her needs? Check all that apply.

- [ ] Activities for care recipient
- [ ] Adult Day Health Programs
- [ ] Children's camperships / after school programs
- [ ] Dealing with stress; stress reduction/relaxation exercises
- [ ] Education/skill building (e.g. managing behavior, personal care)
- [ ] End of Life Issues
- [ ] Friendly Visitor
- [ ] Health Care Proxy
- [ ] Help involving family members in caregiving tasks/facilitated family meeting.
- [ ] Home modification/safety concerns
- [ ] Homemaker
- [ ] Hospice
- [ ] Housekeeping
- [ ] Housing
- [ ] Insurance and benefits counseling
- [ ] Legal information/referral
- [ ] Meals
- [ ] Medicaid (General Info)
- [ ] Mental health referral for care recipient
- [ ] On-going reassurances
- [ ] On-going respite
- [ ] Other
- [ ] Personal care
- [ ] Personal concerns -- caregiver referral to counseling
- [ ] Planned respite (one-time)
- [ ] Powerful Tools for Caregivers
- [ ] Referral to Options Counselor
- [ ] Referral to SHINE
- [ ] Referral to support group
- [ ] Shopping
- [ ] Subsidy/Scholarship - Respite
- [ ] Subsidy/Scholarship - Supplemental Assistance
- [ ] Telephone reassurance
- [ ] Transportation
- [ ] Veterans Benefits Assistance

If Other, what services and support options were discussed with the caregiver to meet her/his current concerns / needs, please specify.

Was a caregiver action plan developed after the assessment was completed?

☐ Yes
☐ No

Signature:

_____

_____

_____

_____

Date

_____/_____/_____

Title : _____ Date

Title : _____ Date

MBA Title III-E Caregiver Questionnaire

Contents **Initials/Date**

MBA 01.28.14 Rev'd

Part I. Caregiver Program Registration

Please complete this form to the best of your ability. Shaded areas are for office use only.

Contact Date	Status	AAA Region	NAPIS ID Number
/ /			- -

Section A. Basic Demographics

Last Name:	First Name:	Middle Initial:
Lives in Rural Area (Circle One): Yes □ No	Gender: □ Female □ Male □Unspecified	Date of Birth: / /

Address:	Address #2:

City:	State:	Zip Code:	County:

Home Phone: ( )	Mobile Phone: ( )	Work Phone: ( )

Section B. Social History

Race (Circle one): □ American Indian/Alaskan □ Asian White Hispanic White not Hispanic 2 or More Races □ Black/African American □ Native Hawaiian/Pacific Islander □ Other

Ethnicity (Circle one)
□ Hispanic or Latino
□ Non-Hispanic

Section C. Care Receiver

What is the care receiver's name?

(Last)_____ (First)_____ (Middle Initial)_____

What is the care receiver's date of birth? _____/_____/_____

What is your relationship to the care receiver? (Circle one)

□ Husband □ Wife □ Son/Son-in-law □ Daughter/Daughter-in-law □ Other Relative

□ Non-Relative □

What is the approximate household income of the care receiver? (Circle one)

1 person in a single or multiple, ***non-spousal*** household

Under $973/month $973 to $1,459/month $1,460 to $1,945/month More than $1,945/month

2 person ***spousal*** household

Under $1,311/month $1,311 to $1,966/month $1,967 to $2,622/month More than $2,622/month

Section D. Use of Information

I understand that the information I am providing on this form is for registration purposes. The information will be used by the Area Agency on Aging and the Minnesota Board on Aging to create statistical reports and may be used by service providers to help identify other services from which I may benefit. This information will not be released to anyone other than the above mentioned parties in a way that will identify me as an individual unless I sign a separate consent for that purpose.

Signature: _____ Today's Date: _____

Part II. Caregiving Questions

What is your most immediate need or concern?

How did you hear about this agency/organization?

☐ **Brochure** ☐ **Newspaper** ☐ **Friend or acquaintance** ☐ **Internet** ☐ **Website**

☐ **Doctor/health clinic** ☐ **Community service/program** ☐ **Other**

Are you currently employed? (Please describe)

☐ **Working full-time** ☐ **Working part-time** ☐ **Not Currently Employed**

Do you live in the same household as the person needing care?

☐ **Yes**
☐ **No If not, what is the distance between households? _____ miles**

Is there anyone else living with you or <NOP> that needs your care or time (e.g., minor children, parent, or other dependent)?

How would you describe your own health?

☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**

What illnesses or medical problems do YOU have that limit your ability to provide care, and do what you need to do? (e.g., chronic pain, diabetes, emphysema, Parkinson's, physical disabilities, mental illness)

Do you have difficulty getting a good night's sleep, 3 or more times per week?

☐ **Yes**
☐ **No**
☐ **Sometimes**

Notes:

Activities of Daily Living

[Note: assistance with two or more ADLs or needs supervision for respite and supp. services]

Can <NOP> walk around inside without any help? ☐ Yes ☐ No	**Can <NOP> bathe or shower without any help? ☐ Yes ☐ No**
Can <NOP> sit up or move around in bed without any help? ☐ Yes ☐ No	**Can <NOP> use the toilet without any help? ☐ Yes ☐ No**
Can <NOP> comb their hair, shave, wash their face, or brush their teeth without any help? ☐ Yes ☐ No	**Can <NOP> dress without any help? ☐ Yes ☐ No**
Can <NOP> get in and out of bed or chair without any help? ☐ Yes ☐ No	**Can <NOP> eat without any help? ☐ Yes ☐ No**

Need for Supervision:

Does <NOP> have issues with memory, thinking, or the ability to make decisions that result in the need for supervision? ☐ Yes ☐ No

Is <NOP> a Veteran? ☐ Yes ☐ No

If Yes, do you or <NOP> receive any Veteran's benefits? Please describe:

Does <NOP> receive assistance from the county or Medical Assistance ☐ Yes ☐ No (ie., does NOP have a county worker?)

What health problems or medical conditions does <NOP> have that need to be managed?

What is your comfort level with <NOP's> medications or treatments?

Are you satisfied with the amount of information you have been given so far about <NOPs> disease or condition (e.g., dementia, stroke, Parkinson's, etc.)? Or, do you have questions that haven't been addressed yet?

☐ Yes ☐ No

Please describe:

What types of UNPAID help or care are you or <NOP> currently receiving from friends, family, neighbors, people from church, or others in the community? (List person, relationship to CG or CR/type of help/how often)

Who would you call in an emergency?

Do you have plans in place for caregiving in the event of an emergency or health care crisis (e.g., who would help/type of help, etc.)?

Do you have concerns about <NOPs> safety? (e.g., falls, driving, cooking, wandering, alcohol or drug use, fire arms, self-harm or harm to you)

☐ **Yes** ☐ **No**

Please describe:

Are there issues that might cause you to consider a higher level of care for <NOP> or a transition into assisted living or a nursing home? (e.g., worsening dementia, falls, incontinence, your physical health, financial or emotional strain, etc.)

Have you and <NOP> done any planning for the future? (Check all that apply)
(CG = caregiver, NOP = older adult)

☐ **Advanced healthcare directive** ☐ **CG** ☐ **NOP**
☐ **Power of attorney** ☐ **CG** ☐ **NOP**
☐ **A will/trust/or estate planning** ☐ **CG** ☐ **NOP**
☐ **Guardianship/Conservatorship** ☐ **CG** ☐ **NOP**

Notes:

Part III: Caregiver Screen*

<Please reflect on your experiences and rate your responses to the statements below. It will help us gain a better understanding of your situation and how to work with you meet your needs>

1. As a result of assisting <NOP>, to what extent have the following aspects of your life changed?					
To what degree have your care responsibilities …	**Not at all**	**A little**	**Moderately**	**A lot**	**A great deal**
(a) Caused conflicts with your relative?	1	2	3	4	5
(b) Decreased time you have to yourself?	1	2	3	4	5
(c) Created a feeling of hopelessness?	1	2	3	4	5
(d) Given your life more meaning?	1	2	3	4	5
(e) Increased the number of unreasonable requests made by your relative?	1	2	3	4	5
(f) Kept you from recreational activities?	1	2	3	4	5
(g) Made you nervous?	1	2	3	4	5
(h) Made you more satisfied with your relationship?	1	2	3	4	5
(i) Caused you to feel that your relative makes demands over and above what he/she needs?	1	2	3	4	5
(j) Caused your social life to suffer?	1	2	3	4	5
(k) Depressed you?	1	2	3	4	5
(l) Given you a sense of fulfillment?	1	2	3	4	5
(m) Made you feel you were being taken advantage of by your relative?	1	2	3	4	5
(n) Changed your routine?	1	2	3	4	5
(o) Made you anxious?	1	2	3	4	5
(p) Left you feeling good?	1	2	3	4	5
(q) Increased attempts by your relative to manipulate you?	1	2	3	4	5
(r) Given you little time for friends and relatives?	1	2	3	4	5

(s) Caused you to worry?	1	2	3	4	5
(t) Made you enjoy being with your relative more?	1	2	3	4	5
(u) Left you with almost no time to relax?	1	2	3	4	5
(v) Made you cherish your time with your relative?	1	2	3	4	5

*Montgomery Burden Scale. Source: Montgomery, R.J.V., E.F. Borgatta & M.L. Borgatta (2000)

Sum Baseline R Score = (a) ___ + (e) ___ + (i) ___ + (m) ___ + (q) ___ = _____
R Score = 13-25 High*; 8-12 Medium*; 5-7 Low

Sum Baseline O Score = (b) ___ + (f) ___ + (j) ___ + (n) ___ + (r) ___ + (u) ___= _____
O Score = 24-30 High*; 18-23 Medium*; 6-17 Low

Sum Baseline S Score = (c) ___ + (g) ___ + (k) ___ + (o) ___ + (s) ___ = _____
S Score = 17-25 High*; 12-16 Medium*; 5-11 Low

**** Note: If scores are in the Medium or High range in ANY one of three burden measures, a referral for a full TCARE® assessment is recommended.***

CES-D Screen

2. The following is a list of the ways you may have felt or behaved recently. For each statement, indicate how many days you have felt this way <u>during the past week</u>.

DURING THE PAST WEEK:	**Rarely or none of the time (less than 1 day)**	**Some or a little of the time (1-2 days)**	**Occasionally or a moderate amt. of time (3-4 days)**	**All of the time (5-7 days)**
a. I was bothered by things that don't usually bother me	1	2	3	4
b. I had trouble keeping my mind on what I was doing	1	2	3	4
c. I felt depressed	1	2	3	4
d. I felt that everything I did was an effort	1	2	3	4
e. I felt hopeful about the future	4	3	2	1
f. I felt fearful	1	2	3	4
g. My sleep was restless	1	2	3	4
h. I was happy	4	3	2	1
i. I felt lonely	1	2	3	4
j. I could not "get going"	1	2	3	4

Source: Center for Epidemiological Studies Depression Scale (CES-D)

Sum* Baseline *CES-D Score: 26-40 High*; 19-25 Medium*; 10-18 Low
**** If scores medium or high a referral to primary care physician is recommended.***

Part IV. Closing Questions

How much time each week do you have to yourself, to get things done, to socialize with family/friends, relax, or for other purposes?
What would you do more of if you had more time away from caring for <NOP>?
After our conversation today, what do you think are the most immediate issues or concerns that need to be addressed or that you need some assistance with? What things would you like us to address first?
Notes/Additional Questions

Part V. Sample Caregiver Plan

Name **Caregiver ID**
Date of Plan
Initial ☐ **Follow-up** ☐ **3 Month** ☐ **6 Month** ☐ **9 Month** ☐ **12 Month**

Goals: <At least one goal should focus on caregiver's health>

Goal: **Desired Outcome:** **Milestone:**		
Goal: **Desired Outcome:** **Milestone:**		
Goal: **Desired Outcome:** **Milestone:**		
Caregiver Consultant Responsibility		
Caregiver Responsibility		
Caregiver Consultant Name	**Signature**	**Date**
Caregiver Name	**Signature**	**Date**

Live Well at Home

Live Well At Home Rapid Screen© – Family Caregiver

Screen Date: _____

1.	**Does <name of older person (NOP)> need help from someone else to do the following?** a) Walking b) Getting out of bed/chair c) Going to the bathroom d) Bathing e) Dressing f) Eating **If 2 or more circled → SCORE = 2**	☐
2.	**During the last 6 months, has <NOP> had a fall that caused injuries *or* engaged in behavior problems such as wandering, verbal or physical disruption, or other behaviors that require supervision? Yes No** NOTE: "Injuries" means fracture or joint dislocation, head injuries resulting in loss of consciousness and hospitalization, joint injuries that led to decreased activity, internal injuries that led to hospitalization OR 3 or more of any falls **IF YES circled → SCORE = 2**	☐
3.	**Does <NOP> have a family member/friend give help when she/he needs it? Yes No** **If NO circled → SCORE = 2**	☐
4.	**Do you feel overwhelmed or stressed because of the care you provide for <NOP>? Yes No** **If YES circled → SCORE = 2**	☐
5.	**Have you/<NOP> thought about moving <NOP> to other housing? Yes No** **If YES, where has <NOP> considered moving to?** **If answered NURSING HOME or ASSISTED LIVING (i.e., Housing With Services) → SCORE = 2**	☐
6.	**Does <NOP> live alone? Yes No** **If YES circled → SCORE = 1**	☐
7.	**Do you or your family have concerns about <NOP's> memory, thinking, or ability to make decisions?** **If YES, are you: Very concerned Somewhat concerned** **If VERY CONCERNED circled → SCORE = 2** **If SOMEWHAT CONCERNED circled → SCORE = 1**	☐
	TOTAL SCORE (Sum of Scores For Items 1 Through 7) =	☐
Score and Risk Category **0 = No Risk 1 = Low Risk 2 = Moderate Risk 3 and Higher = High Risk**		

Initial Assessment

Date of Initial Contact:_____ Name of Interviewer:_____ Date of Assessment:_____

Caregiver Name_____

I prefer to be addressed as:_____

Address: _____

Mailing address (if different from above): _____

Daytime phone:_____ Alt phone:_____ Email:_____

What is the best method to contact you? ☐ Daytime phone ☐ Alt phone ☐ Email

Age of Caregiver: DOB__ /__ /____ or ☐ Under 60 ☐ 60-74 ☐ 75-84 ☐ 85+ ☐ Unknown

Gender of Caregiver**:** ☐ Male ☐ Female

Name of Individual you provide care for:_____

Address (if living in a different location): _____

Length of time you have been caring for this person: _____(in years and months)

How many hours do you usually spend providing care for this individual? _____☐ Day ☐ Week

Who else lives with you, the primary caregiver?_____

How many adults 18 and over? _____ How many younger than 18?_____

Are you caring for anyone else? (i.e. children, other adults, etc.) ☐ No ☐ Yes_____

Are there any communication issues, or do you need an interpreter? ☐ No ☐ Yes If yes, what is needed:

_____

Who is your emergency contact? _____

Who else lives with the person you are caring for? _____

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Veteran:

Has the individual you provide care for ever served in the military or armed forces?

☐ Yes ☐ No ☐ Don't know

[If the answer is yes: "If you served in the active military, naval, or air services and are separated under any condition other that dishonorable, you may qualify for VA healthcare benefits. Current and former members of the Reserves or National Guard who were called to active duty (other than for training only) by a federal order and completed the full period for which they were called or ordered to active duty may be eligible for VA healthcare as well."]

Notes: _____

_____

Referral Source:

How were you referred to the program? ☐ Hospital ☐ Nursing or Rehab ☐ An individual

☐ Home Health Agency/VNA ☐ Adult Day Program ☐ Self-referral ☐ Alz. Assoc. ☐ Other

Section 1: Caregiver Specific Information

Providing the information below regarding finances, ethnicity and race is optional and is not required to determine eligibility. Only responses without personal identifying information will be shared. The U.S. Administration on Aging requires the collection of this information to gain a better understanding of the situations and needs of family caregivers nationwide.

Annual Income:

☐ $0-20,000 ☐ $40,001-60,000

☐ $20,001-40,000 ☐ Over $60,000

☐ Unknown

Marital Status of Caregiver:

☐ Never Married ☐ Living with Partner

☐ Divorced ☐ Widowed

☐ Married ☐ Unknown

Ethnicity of Caregiver:

☐ Hispanic Origin ☐ Non-Hispanic ☐ Unknown

Race of Caregiver:

☐ White Alone ☐ Nat. Hawaiian/Pacific Islander

☐ Black/ African Amer. ☐ Some other race

☐ Amer. Ind./Alaska Nat. ☐ Two or more races

☐ Asian ☐ Unknown

Relationship of Caregiver to Care Recipient: *(The caregiver is the _____of the care recipient)*

☐ Husband ☐ Daughter/Daughter-in-Law

☐ Wife ☐ Other Relative

☐ Partner ☐ Non- Relative

☐ Son/Son-in-Law ☐ Unknown

Financial:

Are you currently employed? ☐ Yes ___ Part-time ___Fulltime ☐ No

If not currently working, what is the main reason you do not work?

☐ Retired ☐ Disabled ☐ Unable to work temporarily

☐ On layoff ☐ On family leave ☐ Left job to provide care

Are you receiving some type of payment to provide care to this individual? **☐ Yes ☐ No

Which of the following best describes the financial situation of your household?

☐ Struggle to make ends meet ☐ Just enough to make ends meet, but no more

☐ Meet our needs with occasional "extras" ☐ Generally comfortable

Are there medications; supplies or treatments that either you and/or the individual you are caring for should have, but cannot afford to buy? ☐ Yes ☐ No

In the next few months, do you anticipate new expenses that will be necessary in order to help keep the individual you are caring for at home (renovations, wheelchair, or assistive equipment)? ☐ Yes ☐ No

Planning Ahead:

Are any of the following in place for the individual you provide care for? *(Check any of the following that apply.)*

A legal guardian	☐ Yes	☐ No	EMS/DNR directives	☐ Yes	☐ No
Special POA for health-care	☐ Yes	☐ No	A funeral plan	☐ Yes	☐ No
DPOA for finances	☐ Yes	☐ No	A burial plan	☐ Yes	☐ No
A living will	☐ Yes	☐ No			

Do you need assistance developing any of the above? ☐ Yes ☐ No _____

Caregiving Experiences & Strengths:

Frequently there are positive aspects of caregiving. What are the most rewarding things for you about providing care to the person you are caring for?_____

_____

Are there qualities and personal strengths that you bring to your caregiving role? _____

_____

How would you say your overall health is? ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

Do you feel you have a good understanding of the individual's condition? _____

Are you comfortable asking other people to be involved in or help in caregiving? ☐ Yes ☐ No

_____

Back Up Plan:

Is there anyone else assisting you with caregiving? ☐ Yes ☐ No _____

Do you currently have anyone available to provide temporary emergency care when you are unable to?

☐ Yes ☐ No _____

Are there challenges as a caregiver that you are concerned about?_____

_____

Are there any circumstances that might prevent you from continuing to provide care at home within the next three to six months? _____

_____

If for some reason you couldn't continue to provide care is there someone who would take over as the primary caregiver?_____

Safety:

Do you have any concerns about the safety of the individual you are caring for? ☐ falling ☐ wandering ☐ Other_____ ☐ No concerns

Do either ☐ you or ☐ the individual you care for feel at risk of verbal abuse, physical abuse, neglect, self-neglect or financial exploitation by another person? _____

Environmental: (interviewer's observations)

Is there safe access to living areas (stairs, steps, doorways)? ☐ Yes ☐ No_____

Is there sufficient heating/air conditioning? ☐ Yes ☐ No_____

Are there concerns about electrical / fire hazards? ☐ Yes ☐ No _____

Is there proper egress/escape plan in case of fire? ☐ Yes ☐ No _____

Are there concerns about yard work/snow removal? ☐ Yes ☐ No _____

Supports and Services:

Does the individual you care for receive any services on a regular basis such as: ☐ Homemaker

☐ Home Health or VNA ☐ VA ☐ Choices for Independence ☐ Other:_____

If yes, can you specify the health provider? _____

Self-Care:

Do you attend a support group, educational, or training sessions? ☐Yes If yes, is it helpful? ☐Yes ☐No

Notes:_____

What you like to see happen over the next six months to a year that would benefit you? (i.e. activities you may have set aside that you used to enjoy)_____

_____

Do you feel:	**Never**	**Rarely**	**Some-times**	**Quite Often**	**Nearly Always**
…that because of the time you spend with *(care recipient's name)* that you don't have enough time for yourself?	☐	☐	☐	☐	☐
…stressed between caring for *(care recipient's name)* and trying to meet other responsibilities (work/family)?	☐	☐	☐	☐	☐
…strained when you are around *(care recipient's name)*?	☐	☐	☐	☐	☐
…uncertain about what to do about *(care recipient's name)*?	☐	☐	☐	☐	☐

Source: Zarit 4-item Caregiver Burden screen**;** Michel Bédard et.al., *The Gerontologist* 41:652-657 (2001)

Section 2: Care Recipient Specific Information

Gender of Care Recipient: ☐ Male ☐ Female

Age of Care Recipient*(required): DOB__ /__ /____ ☐ Under 60 ☐ 60-74 ☐ 75-84 ☐ 85+

Providing the information below is helpful in determining other programs you may be eligible for:

Annual Income:

☐ $0-20,000 ☐ $20,001-40,000
☐ $40,001-60,000 ☐ Over $60,000
☐ Unknown

Assets: (Note: excludes primary home and vehicle)

☐ $0-5,000 ☐ $5,001-10,000
☐ $10,001-20,000 ☐ $20,001-30,000
☐ Over $30,000 ☐ Unknown

The Physical and Mental Status of the Individual Being Cared For:

Instrumental Activities of Daily Living (This information is helpful in identifying potential community supports.)	Yes	No
A. Meal Preparation: Care recipient can prepare breakfast and light meals	☐	☐
B. Telephone: Can use telephone as necessary, e.g., able to contact people in an emergency.	☐	☐
C. Light Housework: can do light housework; washing dishes, dusting (daily basis), making bed.	☐	☐
D. Managing Finances: Can manage own finances**;** banking; handling checkbook; paying bills.	☐	☐
E. Medication: Can take medication on time with correct dose, without assistance.	☐	☐
F. Transportation: Needs transportation and/or escort to medical, dental appointments, necessary engagements, or other activities or needs	☐	☐

	Yes	No
Has the individual been hospitalized or seen in the Emergency Room recently?	☐	☐

Definitions:

Independent: can accomplish with or without assistive devices—No help needed.
Needs assistance, or done with help: Individual involved in activity, but help (including supervision, reminders, and/or physical "hands-on" help) is needed.
Dependent or done by others: Full performance of the activity is done by others.
***Note**: a minimum of two ADL assists in columns # 2 or# 3 or cognitive impairment in categories 2 & 3 below are required for eligibility for Title III-E funded services*

Activities of Daily Living	Ind.	Asst.	Dep.
Transfers: How individual moves to/from: bed, chair, wheelchair, or standing	☐	☐	☐
Walking/Mobility: How individual walks or moves between locations in his/her room and other areas on same floor. If in wheelchair, self-sufficiency once in chair.	☐	☐	☐
Dressing: How individual puts on, fastens, and takes off all items of clothing	☐	☐	☐
Eating: How individual eats and drinks (regardless of skill)	☐	☐	☐
Bathing /Personal Hygiene: How individual takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower; maintains personal hygiene, including combing hair, brushing teeth, shaving, washing/ drying face, & hands.	☐	☐	☐
Toilet Use: How individual uses the toilet; transfers on/off toilet, cleans self, adjusts clothes; occasionally incontinent; frequently incontinent; or incontinent all of the time.	☐	☐	☐

Cognition:	Yes	No
1. Individual has a Doctor's diagnosis of Alzheimer's disease or other type of dementia.	☐	☐
2. It is no longer safe for the individual to be left alone.	☐	☐
3. The individual is no longer able to follow through with reminders or prompts.	☐	☐

- How many hours each day can the individual safely be left alone? _____ Hours

_____

_____

Assistance		***Note:*** Check the services the caregiver has used, or might benefit from, if available.			
Have Used	**Could Use**		**Have Used**	**Could Use**	
☐	☐	Nursing care at home	☐	☐	Training on providing care
☐	☐	Personal Care	☐	☐	Counseling
☐	☐	Homemaker services	☐	☐	Transportation
☐	☐	Chore services	☐	☐	Home Modifications
☐	☐	Adult Day	☐	☐	Occupational Therapy
☐	☐	Financial/Medical assistance	☐	☐	Assistive Technology
☐	☐	Legal assistance	☐	☐	Fuel Assistance
☐	☐	Respite-in home	☐	☐	Home Repairs/Safety
☐	☐	Respite -Facility	☐	☐	Alternative Housing
☐	☐	Support Group	☐	☐	Veteran's Benefits
☐	☐	Home Delivered Meals	☐	☐	Other:

How might these services be paid for?_____

Would information on any of the following areas be helpful to you?

Medicare counseling ☐ Yes ☐ No
Long Term Care Options ☐ Yes ☐ No
LTC Insurance ☐ Yes ☐ No
Pharmacy Benefits ☐ Yes ☐ No
Education or training on how to care for yourself as a caregiver? ☐ Yes ☐ No
Opportunity to talk with a group of people in a similar situation, such as a support group? ☐ Yes ☐ No

Are there any other issues that you are concerned about that we didn't cover?

_____

_____

****

Notes:_____

_____

_____

_____

_____

_____

SECTION M: CAREGIVER INFORMATION

CAREGIVER 1 INFORMATION — FOR PRIMARY CAREGIVER

First Name: Click here to enter text.	**Last name:** Click here to enter text.	**Phone Number :** Click here to enter text.

Caregiver's relationship to care recipient:

☐ Parent	☐ Spouse/Significant Other	☐ Son/Daughter
☐ Grandparent	☐ Sibling	☐ Other Relative
☐ Neighbor	☐ Friend	☐ Other — Specify: Click here to enter text.

Does the caregiver live with the individual? ☐ Yes ☐ No
Is the caregiver trained? ☐ Yes ☐ No

CAREGIVER 2 INFORMATION

First Name: Click here to enter text.	**Last Name:** Click here to enter text.	**Phone Number:** Click here to enter text.

Caregiver's relationship to care recipient:

☐ Parent	☐ Spouse/Significant Other	☐ Son/Daughter
☐ Grandparent	☐ Sibling	☐ Other Relative
☐ Neighbor	☐ Friend	☐ Other — Specify: Click here to enter text.

Does the caregiver live with the individual? ☐ Yes ☐ No
Is the caregiver trained? ☐ Yes ☐ No

CAREGIVER 3 INFORMATION

First Name: Click here to enter text.	**Last Name:** Click here to enter text.	**Phone Number:** Click here to enter text.

Caregiver's relationship to care recipient:

☐ Parent	☐ Spouse/Significant Other	☐ Son/Daughter
☐ Grandparent	☐ Sibling	☐ Other Relative
☐ Neighbor	☐ Friend	☐ Other — Specify: Click here to enter text.

Does the caregiver live with the individual? ☐ Yes ☐ No
Is the caregiver trained? ☐ Yes ☐ No

Caregiver Profile (for primary caregiver only)			
Are you paid to provide care for [care recipient's name]?	☐ Yes	☐ No	**(If Yes, stop here)**
Is there another person who provides care or could provide care if you were unable?	☐ Yes	☐ No	**If Yes, provide the name and relationship to the individual.**
Are you the only non-paid person providing care to (care recipient's name)?			☐ Yes ☐ No
How long have you provided care for (care recipient's name)?	☐ year(s)		☐ month(s)

How often do you provide care to (care recipient's name)? ☐ Daily ☐ Weekly ☐ Monthly ☐ Less than once per month

Do you have children younger than 18? ☐ Yes ☐ No

Are you also providing care to any other individuals? ☐ Yes ☐ No

Distance to care recipient's home: (Select one) ☐ 0–10 miles ☐ 11–40 miles ☐ 41–100 miles ☐ Over 100 miles

Caregiver Employment and School (for primary caregiver only)			
Are you employed?	☐ Full-time	☐ Part-time	☐ Not Employed
Are you enrolled in school?	☐ Full-time	☐ Part-time	☐ Not In School
Have your caregiver responsibilities ever affected your employment or school?	☐ Yes	☐ No (If No, go to Caregiver Skills and Training Assessment Section)	

Comments: Click here to enter text.

If employed, how has your employment been affected? (Select all that apply)

Schedule	Pay	Leave	Work Relationships	Performance
☐ Changed jobs	☐ Has taken a second job	☐ Takes leave frequently	☐ Feeling of isolation	☐ Decreased confidence in own ability
☐ Decreased hours or went part-time	☐ Has lost wages or periods with no income	☐ Used all paid leave; no leave remaining	☐ Less co-worker interaction	☐ Decrease in productivity
☐ Has taken extended leave with pay	☐ Has taken leave without pay (LWOP)	☐ Exceeded Family Medical Leave Act (FMLA)	☐ Tension or problem with co-worker	☐ Difficulty with concentration or focus
☐ Quit job	☐ Missed promotion opportunity		☐ Tension or problem with supervisor	☐ Fear of losing job
	☐ Received pay cut or pay decreased			☐ Perform or manage caregiver tasks at work

Caregiver Stress Interview (for primary caregiver only)					
Do you find caring for (care recipient's name) to be stressful?				☐ Yes	☐ No
How would you rate your stress level:			☐ Low	☐ Moderate	☐ High
Do you have a chronic health condition or have you experienced a recent hospitalization? (If No, go to Employment Section)	☐ Yes	☐ No	**Caregiver's health condition/crisis:** Click here to enter text.		
Has this health condition affected your ability to care for (care recipient's name)?	☐ Yes	☐ No			

Select the response that best describes how you feel	**Strongly Disagree**	**Disagree**	**Neither Agree nor Disagree**	**Agree**	**Strongly Agree**
I feel a sense of satisfaction helping (care recipient's name).	☐	☐	☐	☐	☐
I am confident about providing care to (care recipient's name).	☐	☐	☐	☐	☐
Caring for (care recipient's name) while trying to meet other responsibilities for my family or work is causing increased stress.	☐	☐	☐	☐	☐
I feel a sense of obligation to provide care.	☐	☐	☐	☐	☐
My health has suffered because of my involvement with providing care.	☐	☐	☐	☐	☐
My finances are strained because I provide care.	☐	☐	☐	☐	☐
I could do a better job of caring for (recipient's name)	☐	☐	☐	☐	☐

What do you do to cope with the stress related to the challenges of caregiving? Describe: Click here to enter text.

Is this working to help relieve stress?	☐ Yes	☐ Somewhat	☐ Not at all

Caregiver Skills and Training Assessment (for primary caregiver only)

Do you need information, education, and/or training about the following? (Select all that apply)

- ☐ How to care for yourself while caring for others
- ☐ Individual counseling options
- ☐ Legal and financial issues, powers of attorney, living will
- ☐ Online information and supports
- ☐ Long-term care options (insurance and/or other benefits)
- ☐ More information about care recipient's disease/condition
- ☐ Support groups
- ☐ Home safety and/or home modifications, or equipment
- ☐ In-home support services
- ☐ Choosing a long-term care facility
- ☐ How to provide care to an aging individual
- ☐ Short-term respite care in a facility
- ☐ How to get other family members to help
- ☐ Coordinating the individual's medical care
- ☐ Skills training for personal care tasks (e.g. bathing, grooming, toileting, etc.)
- ☐ Meeting other families that have individual with similar needs
- ☐ Finding or working with doctors or specialists
- ☐ Coordinating and making appointments with individual's social services agency

Other, please describe: Click here to enter text.

Have you received caregiver support services in the past?	☐ Yes	☐ No

Notes/Comments (as needed): Click here to enter text.

Assessor Observations (select all that apply) **(for primary caregiver only)**

- ☐ Are there concerns about caregiver support?
- ☐ Caregiver has history or evidence of substance abuse.
- ☐ Caregiver has history or evidence of mental health issues.
- ☐ Other concerns or observations (please describe): Click here to enter text.

Notes/Comments (as needed): Click here to enter text.

State of Rhode Island Department of Human Services
Division of Elderly Affairs

Long Term Services and Supports Caregiver Assessment

Client name: _____

Caregiver name: _____

Date: _____

1. ***What is your relationship with the person receiving care?*** _____
2. ***How often are you consistently providing care?***
   - Daily or multiple times daily Yes ____ No ____
   - Several times per week Yes ____ No ____
   - Once a week Yes ____ No ____
   - Less than once a week Yes ____ No ____

How many hours per week do you provide care? _____

***How long have you been providing this care?*_____**

Do you have to travel to provide this care? If so, how far? Yes ____ No ____ _____

3. ***What kind of care do you provide?*** ***How often do you provide this care?***
   - Personal Care Yes ____ No ____ _____
   - Housekeeping/Meal Prep Yes ____ No ____ _____
   - Transportation Yes ____ No ____ _____
   - Shopping/errands Yes ____ No ____ _____
   - Supervision for safety Yes ____ No ____ _____
   - Money management Yes ____ No ____ _____
   - Redirection, Cueing Yes ____ No ____ _____
   - Spending your personal funds Yes ____ No ____ _____
   - Other _____
4. ***Does anyone share the caregiver responsibilities with you?*** If yes, who_____
5. ***Do your responsibilities as a caregiver cause you to worry about:***
   - Work (lost time, decreasing hours, quitting work) Yes ____ No ____
   - Family relationships/responsibilities (kids sports activities, spousal relationships) Yes ____ No ____
   - Financial matters both my loved one's and my own Yes ____ No ____
   - My own health, both physical and mental Yes ____ No ____
   - Lost sleep and how it is affecting my well- being Yes ____ No ____
   - What the future may bring and how I will manage it all Yes ____ No ____
   - That I cannot provide the care that is necessary, Yes ____ No ____

- Behavioral issues of the person I care for. Yes ____ No ____

6. ***Does your role as a caregiver cause you emotional distress?*** Yes ____ No ____
7. ***What resources/services would best help <u>you</u>, in your role as a caregiver? _____***
   (personal assistance for care recipient, respite, informational materials, support groups?)
8. ***If you were ever unable to continue to care for _____ is there someone to take your place? Do you have a back-up plan? _____***
9. ***How would you rate your own health?***
   Excellent _____ Good _____ Fair _____ Poor _____ No response _____
   Is it better or worse since you began your role as caregiver?_____
10. ***Are you getting support in your role as a caregiver ?*** Yes ____ No ____
    If yes, from whom? _____
11. ***Would you like information about caregiver resources in addition to information about services*? _____**

Caregiver chooses not to participate _____.

ELIGIBILITY FOR TITLE III-E SERVICES

1 **To qualify as a FAMILY CAREGIVER, at least one of the following statements (A or B) must be true:**

A. The Family Caregiver is an adult family member (age 18 years or older) or other adult informal caregiver providing care to an individual 60 years of age or older. ☐ True ☐ False

Priority:	*Is the caregiver an older individual who has a **great social or economic need** (especially a low-income older caregiver)?*	☐ *Yes*
Priority:	*Is the caregiver an older individual who is caring for a **person with severe disabilities**?*	☐ *Yes*

OR B. The Family Caregiver is an adult family member (age 18 years or older) or other adult informal caregiver providing care to an individual of any age with Alzheimer's disease or related disorder. ☐ True ☐ False

Priority:	*Is the Alzheimer's **care receiver 60 or older**?*	☐ *Yes*

2 **For a FAMILY CAREGIVER to qualify for Respite and/or Supplemental Services requiring Title III-E vouchers one of the following statements must be true:**

A. The Care Receiver is **unable to perform at least two (2) ADLs** without substantial human assistance, including verbal reminding, physical cueing, or supervision. ☐ True ☐ False

OR B. Due to a **cognitive or other mental impairment**, the Care Receiver requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or someone else. ☐ True ☐ False

What level of assistance does the *care receiver* need to complete the following Activities of Daily Living?

Substantial Human Assistance *

* *Including verbal reminding, physical cueing, or supervision*

	[0 = Independence] 0	1	2	3	4	5 *[5 = Total dependence]*
Ambulation						
Dressing						
Eating						
Bathing						
Toileting						
Transferring						

Substantial Human Assistance *

	[0 = Continence] 0	1	2	3	4 *[4 = Incontinence]*
Bowel Continence					
Bladder Continence					

3 **Does the FAMILY CAREGIVER qualify for respite and other funded services?** ☐ Yes ☐ No

ELIGIBILITY FOR TITLE III-E SERVICES

4 **To qualify as a GRANDPARENT OR RELATIVE RAISING A CHILD**
or as a GRANDPARENT OR RELATIVE RAISING A DISABLED ADULT CHILD
all six of the following statements (a - f) MUST be true:

a.	The caregiver is the **grandparent** or stepgrandparent of the child , or is a relative of the child by blood, marriage, or adoption (but NOT the Parent or the Spouse).	☐ True	☐ False
b.	The caregiver is is **55 years or older**.	☐ True	☐ False
c.	The caregiver **lives with the child**.	☐ True	☐ False
d.	The caregiver is the **primary caregiver** of the child because the biological or adoptive parents are unable or unwilling to serve as the primary caregiver of the child;	☐ True	☐ False
e.	The caregiver has a legal relationship to the child or is raising the child informally.	☐ True	☐ False
f.	**The child is 18 years or younger.** (Does not need to meet ADL requirements.)	☐ True	☐ False
	OR		
	The child is a disabled adult between 19 and 59 years with substantial limitations in one (1) or more areas of major life activity.	☐ True	☐ False

Priority: Is the 'child' severely disabled? (see below) ☐ *Yes*

5 **Does the GRANDPARENT or RELATIVE RAISING A CHILD qualify for funded services?**

☐ Yes ☐ No

The term **"disability"** means a disability attributable to mental or physical impairment, or a combination of mental and physical impairments, that results in **substantial functional limitations in 1 or more** major life activities below.

The term **"severe disability"** means a severe, chronic disability attributable to mental or physical impairment , or a combination of mental and physical impairments that—

A) is **likely to continue indefinitely**, and

B) results in **substantial functional limitation in 3 or more** of the major life activities below.

a. self-care,
b. receptive and expressive language,
c. learning,
d. mobility,
e. self-direction,
f. capacity for independent living,
g. economic self-sufficiency,
h. cognitive functioning, and
i. emotional adjustment.

South Carolina
Family Caregiver Support Program

Family Caregiver Support Program
Release and Authorization Form
To be completed by Family Caregiver

I authorize _____ to provide the information needed to complete the Eligibility Form. I authorize the release of this information to the Family caregiver Advocate for the Family Caregiver Support Program. The purpose of this release is to provide health verification and to serve as a release for the FCSP to provide services. All records are kept in the strictest confidence and the information is used only for purposes of evaluating client needs and to track services.

Care Receiver _____

Date of Birth _____

Address _____

Phone _____

_____ _____ _____
Caregiver's Signature Relationship to Care Receiver Date

_____ _____
Care Receiver's Signature (If applicable) Date

Family Caregiver Support Program
Eligibility Assessment

This form is to be completed and signed by a health care professional; Doctor, Nurse,

Social Worker, Case Manager

Care Receiver: _____ Caregiver_____

1. What level of assistance does the Care Receiver need to complete the following Activities of Daily Living?

Substantial Human Assistance*

*Including verbal reminding,, physical cueing or supervision

(Independent)	0	1	2	3	4	5 (Total care)
Ambulation						
Dressing						
Eating						
Bathing						
Toileting						
Bowel Continence						
Bladder Continence						

2. Due to a **cognitive or other mental impairment,** does the Care Receiver require substantial supervision to maintain their health and safety?

☐ Yes ☐ No

3. Give Diagnoses/List Significant Health Problems:

_____ _____

_____ _____

_____ _____

_____ _____ _____

Health Care Professional Signature Date Agency

_____ _____

Print Name Phone Number

Please complete and return to:

SD Caregiver Assmt

A. CAREGIVER/CARE RECEIVER PROFILE

A.1. CAREGIVER INFORMATION

What is the CAREGIVER'S FIRST NAME?

_____

What is the CAREGIVER'S MIDDLE INITIAL?

_____

What is the CAREGIVER'S LAST NAME?

_____

What is the CAREGIVER'S RESIDENTIAL STREET ADDRESS?

_____

What is the CAREGIVER'S MAILING ADDRESS, if different from the residential street address?

_____

Enter the CAREGIVER'S RESIDENTIAL CITY OR TOWN.

_____

Enter the CAREGIVER'S STATE of residence.

_____

Enter the CAREGIVER'S RESIDENTIAL ZIP CODE.

_____

Enter the CAREGIVER'S TELEPHONE NUMBER, including area code.

_____

What is the CAREGIVER'S DATE OF BIRTH?

_____/_____/_____

What is the CAREGIVER'S GENDER?

- ☐ 1 - Male
- ☐ 2 - Female

What is the CAREGIVER'S ETHNICITY?

- ☐ 0 - Not Hispanic or Latino
- ☐ 1 - Hispanic or Latino

What is the CAREGIVER'S RACE?

- ☐ 1 - White
- ☐ 2 - American Indian or Alaska Native
- ☐ 3 - Asian
- ☐ 4 - Black or African American
- ☐ 5 - Native Hawaiian or Other Pacific Islander
- ☐ 6 - Other

What is the CAREGIVER'S MARITAL STATUS?

- ☐ 1 - Never Married
- ☐ 2 - Married
- ☐ 3 - Partner / Significant Other
- ☐ 4 - Widowed
- ☐ 5 - Separated
- ☐ 6 - Divorced

What is the CAREGIVER'S SOCIAL SECURITY NUMBER?

_____-_____-_____

Is the CAREGIVER'S income level below the national POVERTY level?

- ☐ 0 - No
- ☐ 1 - Yes

A.2. CARE RECEIVER INFORMATION

What is the CARE RECEIVER'S FIRST NAME?

_____

What is the CARE RECEIVER'S LAST NAME?

_____

Enter the CARE RECEIVER'S RESIDENTIAL ADDRESS, if different from caregiver.

_____

_____

_____

_____

Enter the TELEPHONE NUMBER of the CARE RECEIVER, if different from caregiver.

_____

Select the CARE RECEIVER'S current LIVING ARRANGEMENT.

- ☐ 1 - Alone
- ☐ 2 - With spouse / partner only
- ☐ 3 - With spouse / partner and other(s)
- ☐ 4 - With child (not spouse / partner)
- ☐ 5 - With parent(s) or guardian(s)
- ☐ 6 - With sibling(s)
- ☐ 7 - With other relative(s)
- ☐ 8 - With non-relative(s)

What is the CARE RECEIVER'S DATE OF BIRTH?

_____/_____/_____

What is the GENDER of the CARE RECEIVER?

- ☐ 1 - Male
- ☐ 2 - Female

Describe the CARE RECEIVER'S MEDICAL CONDITIONS, as reported by the caregiver.

Has the CARE RECEIVER been diagnosed with ALZHEIMER'S DISEASE or other RELATED DEMENTIA?

- ☐ 0 - No
- ☐ 1 - Yes

Does the CARE RECEIVER'S household have any UNMET NEEDS regarding ASSISTIVE DEVICES OR MEDICAL EQUIPMENT?

- ☐ 0 - No
- ☐ 1 - Yes

Is the CARE RECEIVER eligible for or receiving any ASA SERVICES?

- ☐ 0 - No
- ☐ 1 - Yes

A.3. CAREGIVING DETAILS

What is the relationship of the PRIMARY CAREGIVER TO the CARE RECEIVER?

- ☐ 1 - Husband
- ☐ 2 - Wife
- ☐ 3 - Son/Son-in-law
- ☐ 4 - Daughter/Daughter-in-law
- ☐ 5 - Other Relative
- ☐ 6 - Non-Relative

Is the PRIMARY CAREGIVER PAID TO PROVIDE ASSISTANCE to the Care Receiver?

- ☐ 0 - No
- ☐ 1 - Yes

How often does the PRIMARY CAREGIVER PROVIDE ASSISTANCE to the care receiver?

- ☐ 1 - Several times during day
- ☐ 2 - Once daily
- ☐ 3 - Five or more times per week
- ☐ 4 - Less than 5 times per week
- ☐ 5 - Monthly

Does the PRIMARY CAREGIVER HELP the care receiver with any ADL TASKS? If yes, list.

Does the PRIMARY CAREGIVER HELP the care receiver with any IADL TASKS? If yes, list.

Does the PRIMARY CAREGIVER have any OTHER CAREGIVING RESPONSIBILITIES? (Children, other adults, etc.)

What is the PRIMARY CAREGIVER'S EMPLOYMENT STATUS?

- ☐ 1 - Full-time
- ☐ 2 - Part-time
- ☐ 3 - Fully Retired
- ☐ 4 - Retired, works part-time
- ☐ 5 - Not Employed
- ☐ 6 - Other (List in Notes)

A.4. IMPACT OF CAREGIVING

Which of the following areas are a BURDEN to the PRIMARY CAREGIVER as a result of providing care to the care receiver?

- ☐ 1 - Emotional health
- ☐ 2 - Family responsibilities
- ☐ 3 - Finances
- ☐ 4 - Job
- ☐ 5 - Physical health
- ☐ 6 - Other (Describe in Notes)

Because of providing care to the care receiver, the PRIMARY CAREGIVER FEELS that s/he (check all that apply):

- ☐ Does not have enough time for him/herself
- ☐ Does not have enough privacy
- ☐ Is unable to take care of the care receiver much longer

A.5. SECONDARY CAREGIVER

Is there a SECONDARY CAREGIVER who provides care on a regular basis?

- [ ] 0 - No
- [ ] 1 - Yes

What is the NAME of the SECONDARY CAREGIVER?

_____

What is the RELATIONSHIP of the SECONDARY CAREGIVER to the CARE RECEIVER?

- [ ] 1 - Husband
- [ ] 2 - Wife
- [ ] 3 - Son/Son-in law
- [ ] 4 - Daughter/Daughter-in-law
- [ ] 5 - Other Relative
- [ ] 6 - Non-Relative
- [ ] 7 - None Exists

A.6. COMMUNITY SUPPORTS

If the CAREGIVER PARTICIPATES in a SUPPORT OR DISCUSSION GROUP, describe the group and frequency of attendance.

_____

_____

_____

_____

Does the CAREGIVER have TROUBLE UNDERSTANDING THE BEHAVIORS of the care receiver?

- [ ] 0 - No
- [ ] 1 - Sometimes
- [ ] 2 - Yes

Does the CAREGIVER NEED TRAINING to better understand the diagnosis and how to better manage this diagnosis?

- [ ] 0 - No
- [ ] 1 - Sometimes
- [ ] 2 - Yes

Is the CARE RECEIVER WILLING TO ACCEPT CARE FROM OTHERS?

- [ ] 0 - No
- [ ] 1 - Yes

B. OUTCOME

B OUTCOME

What SERVICES AND SUPPORT OPTIONS were discussed with the caregiver TO MEET her/his CURRENT NEEDS? Please check all that apply.

- ☐ 1 - Support groups
- ☐ 2 - Training to better understand medical condition/behaviors
- ☐ 3 - Counseling
- ☐ 4 - Respite
- ☐ 5 - Supplemental Services (assistive device, incontinence supplies, etc.)
- ☐ 6 - Chore Services
- ☐ 7 - Homemaker/Personal Care
- ☐ 8 - Nursing Services
- ☐ 9 - Home modification

What was the outcome of the assessment?

- ☐ Eligible - Authorized Services
- ☐ Eligible - Caregiver Refused Services
- ☐ Ineligible for Services
- ☐ Referred to Other Services

Title : _____ Date

Title : _____ Date

CAREGIVER FORM 2010a

Caregiver Assessment Instructions

Eligibility

The person receiving services under the National Family Caregiver Support Program (NFCSP) is the Caregiver. In this assessment Client refers to the Caregiver. Eligible Caregivers to receive services under the NFCSP include:

- Adult family members (18 or older) or other adult informal caregivers providing care to individuals 60 years of age and older.
- Adult family members (18 and older) or other adult informal caregivers providing care to individuals of any age with Alzheimer's disease and related disorders.
- Grandparents and other relatives (not parents) 55 years of age and older providing care to children 18 years of age and younger.
- Grandparents and other relatives (not parents) 55 years of age and older providing care to adults, age 19 to 59 years, with disabilities.

Frail Guidelines

To receive Respite or Supplemental services under the NFCSP, the care recipient must meet frail guidelines. Frail means, with respect to an older individual in a State, that the older individual is determined to be functionally impaired because the individual –

(A) (i) is unable to perform at least two activities of daily living without substantial human assistance, including verbal reminding, physical cueing, or supervision; or

(ii) at the option of the State, is unable to perform at least three such activities without such assistance; or

(B) due to cognitive or other mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or to another individual.

For the state of Tennessee, we have adopted (A)(i) having a minimum of two (2) ADL limitations or (B) has a cognitive or other mental impairment that requires substantial supervision to prevent harm to self or others.

Any of the five NFCSP service categories may be provided to grandparents, step-grandparents, and other older relative caregiver caring for a child.

Record Requirements

For the NFCSP there must be at least two records linked in SAMS; one for the Caregiver and one for the Care Recipient. This Caregiver assessment is to be completed on the Caregiver. A separate record must be created for the Care Recipient, using the SAMS ILA 2010 assessment. At a minimum, for the Care Recipient in the SAMS ILA 2010, the following sections must be completed:

- Section 0.A. – Client Identification
- Section 2 – Functional Assessment

I. Profile

I.A. Caregiver Identification

16. What is the client's social security number (SSN)? – Enter the client's social security number. If you have only collected the last 4 digits of the social security number, you should enter "0" for the 5 digits prior to the last 4 digits.

17. Enter the primary local client identifier for the client. - The client identifier establishes a single file for each client for use in recording ALL services received from aging network agencies from all providers. If this is a new client, a number will be automatically generated from the client's date of birth and the last four digits of the Social Security number when the information is entered into the computer database. This number will be the same, no matter where the client receives services. It is critical that you ensure the accuracy of the numbers used to create the Client ID. If the numbers are incorrect, the client will appear as two different people in the database. This will result in inaccurate counts of individuals served by the various programs.

I.B. Caregiver Profile

5. What is the care receiver's status? – This question is used to determine if a client (caregiver) is eligible to receive services under the NFCSP. Mark the appropriate status of the Care Receiver.

7. Does the client have any other caregiving responsibilities? – List any other caregiving responsibilities that the client may have. For instance, caring for children or other adults who may not meet the eligibility criteria for the NFCSP; however, the caregiver is providing them care.

8. Describe any significant changes or events that have taken place in the client's life during the last six (6) months? – If there have been changes, give brief description of those changes.

10. What contacts/services/supportive interventions have been provided for the client? – If the client is receiving services through other programs to assist them in providing care to the care recipient, list what services they are receiving and through which program they are receiving those services.

II. Caregiver Tasks

II.A. Type of Service

1. Does the client provide the care recipient with personal care? – Mark the appropriate response. Personal care includes help with bathing, dressing, toileting, shampooing hair, feeding, and transferring in and out of bed.

2. Does the client help the care recipient with housekeeping? – Mark the appropriate response. Housekeeping includes help with meal preparation, laundry, dishes, sweeping, vacuuming, mopping, and dusting.

3. Does the client help the care recipient manage his/her money? – Mark the appropriate response. Money management includes check writing, bank transactions, paying bills, investigating billing errors, and making investments.

4. Does the client help the care recipient with shopping and/or errands? – Mark the appropriate response. Shopping/Errands includes shopping for food, medicines, clothing, and personal items and running errands for the care recipient.

5. Does the client help the care recipient with taking medication? – Mark the appropriate response. Medication management includes dispensing medications and supervising with taking medications.

6. Does the client provide the care recipient with transportation? – Mark the appropriate response. Transportation includes transporting person for medical appointments, shopping, recreational or educational activities, visiting family or friends, and making arrangements for the person's transportation needs.

7. Does the client provide the care recipient with other assistance? – Mark the appropriate response. Ask the client whether they provide any other assistance that has not already been addressed to the care recipient and include in comment section.

III. Impact of Caregiving

III.A. Caregiver Challenges

Initial Assessment – If this is an initial assessment, you are trying to determine if these aspects of their lives have suffered since they began providing care for the care recipient.

Reassessment – If this is a reassessment, you are trying to determine if these aspects of their lives have continued to suffer since they began receiving services. Receiving services may not for some caregivers make things completely better; however, you are trying to determine if receiving services have helped any with their caregiving responsibilities.

If there have been no changes since the initial assessment, then talk about what changes could be made to better help with their caregiving needs.

1. How does the client rate his/her health? – Ask the client how their health is, using categories on the form. Make sure you record their opinion of how they would rate their health. This could be an indication of their potential to continue providing care.

3. Does the client feel that his/her health has suffered because of involvement with the care recipient? – Health problems of the client could prevent the caregiver from continuing to provide care.

4. Does the client feel that the care recipient affects his/her relationship with family members/friends in a negative way? – The extent to which the client feels that their relationships with family and friends has suffered because of them caring for the care recipient, can affect the amount of stress or burnout a client may be dealing with. This may be because of not having enough time to spend with family and friends away from the care recipient.

5. Does the client feel that his/her social life has suffered because s/he is caring for the care recipient? – The client my struggle with a diminished social life and feel that because they are caring for the care recipient they may not have the time to have a social life as they once did.

9. Does the client feel angry when s/he is around the client? – Client may feel angry about the increased dependency of the care recipient and the many demands on their time, energy, money, as well as other things.

Caregiver Form 2010a

I. Profile

I.A. Caregiver Identification

1. What is the date of the assessment?

_____/_____/_____

2. Specify the type of assessment, or the reason for the assessment.

- ☐ Initial assessment
- ☐ Reassessment

3. What is the name of the person conducting this assessment?

_____

4. What is the name of the agency the assessor works for?

_____

5. What is the client's first name?

_____

6. What is the client's last name?

_____

7. What is the client's middle initial?

_____

8. Enter the client's residential street address or Post Office box.

_____

9. Enter the client's residential city or town.

_____

10. Enter the client's state of residence.

_____

11. Enter the client's residential zip code.

_____

12. Enter the client's mailing street address or Post Office box.

_____

13. Enter the client's mailing city or town.

_____

14. Enter the client's mailing state.

_____

15. Enter the client's mailing ZIP code.

_____

16. What is the client's social security number (SSN)?

_____-_____-_____

17. Enter the primary local client identifier for the client.

_____

18. Enter the client's telephone number.

_____

19. Alternate telephone number for client

_____

20. What is the client's gender?

- ☐ Female
- ☐ Male

21. What is the client's date of birth?

_____/_____/_____

22. Enter the age of the client in years.

☐

23. Select the client's current marital status.

- ☐ Divorced
- ☐ Legally Separated
- ☐ Married
- ☐ Single
- ☐ Widowed

24. What is the client's primary caregiver's ethnicity?

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

25. What is the client's race?

- [ ] American Indian/Native Alaskan
- [ ] Asian
- [ ] Black/African American
- [ ] Missing
- [ ] Native Hawaiian/Other Pacific Islander
- [ ] Non-Minority (White, non-Hispanic)
- [ ] Other
- [ ] White-Hispanic

26. Is the client currently employed?

- [ ] Full time
- [ ] Part time
- [ ] No

I.B. Caregiver Profile

1. What is the care recipient's last name?

_____

2. What is the care recipient's first name?

_____

3. Does the client live with the care recipient?

- [ ] No
- [ ] Sometimes
- [ ] Yes

4. What is the relationship of the client to the care recipient?

- [ ] Daughter/Daughter-in-law
- [ ] Grandparent (60+)
- [ ] Husband
- [ ] Non-relative
- [ ] Other elderly non-relative (55+)
- [ ] Other elderly relative
- [ ] Other relative
- [ ] Relationship Missing
- [ ] Son/Son-in law
- [ ] Wife

5. What is the care recipient's status.

- [ ] Alzheimer's disease or related disorder
- [ ] Client elderly (60+)
- [ ] Disabled (18 to 59)
- [ ] Minor (18 and under)

6. How long has client provided most of the care?

- [ ] Less than 6 months
- [ ] 6 to 12 months
- [ ] 1 to 2 years
- [ ] 2 to 5 years
- [ ] 5+ years

7. Does the client have any other caregiving responsibilities? (Children, other adults, etc.)

_____

_____

_____

_____

8. Describe any significant changes or events that have taken place in the client's life during the last six months.

_____

_____

_____

_____

9. Are there other persons who can assist the client with the care recipient if the client is not available?

- [ ] No
- [ ] Yes

10. What contacts/services/supportive interventions have been provided for the client?

_____

_____

_____

_____

11. Do others assist the client with the care recipient?

- [ ] No
- [ ] Yes

II. Caregiving Tasks

II.A. Type of Service

1. Does the primary client provide the care recipient with personal care?

- ☐ Yes
- ☐ No

2. Does the client help the care recipient with housekeeping?

- ☐ Yes
- ☐ No

3. Does the client help the care recipient manage his/her money?

- ☐ Yes
- ☐ No

4. Does the client help the care recipient with shopping and/or errands?

- ☐ Yes
- ☐ No

5. Does the client help the care recipient with taking medication?

- ☐ Yes
- ☐ No

6. Does the client provide the care recipient with transportation?

- ☐ Yes
- ☐ No

7. Does the client provide the care recipient with other assistance?

- ☐ Yes
- ☐ No

8. If services were not in place, would there be anything that would make it difficult for the client to provide care?

- ☐ Yes
- ☐ No

9. How often does the care recipient receive assistance from the client?

- ☐ Monthly
- ☐ Weekly
- ☐ One to two times per week
- ☐ Three or more times per week
- ☐ Once daily
- ☐ Several times during day
- ☐ Several times during day and night

III. Impact of Caregiving

III.A. Caregiver Challenges

1. How does the client rate his/her health?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

2. Does the client feel that s/he has lost control of his/her life since the care recipient became ill?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

3. Does the client feel that his/her health has suffered because of involvement with the care recipient?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

4. Does the client feel that the care recipient affects his/her relationship with family members/friends in a negative way?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

5. Does the client feel that his/her social life has suffered because s/he is caring for the care recipient?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

6. Does the client feel that s/he doesn't have enough privacy because of caring for the care recipient?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

7. Does the client feel that s/he does not have enough time for him/herself because of the time spent caring for the care recipient?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

8. Does the client feel stressed between caring for the care recipient and trying to meet other responsibilities?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

9. Does the client feel angry when s/he is around the care recipient?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

10. Does the client feel that s/he does not have enough money to take care of the care recipient and pay for the rest of his/her expenses?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

11. Overall, does the client feel burdened caring for the care recipient?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

12. Indicate the behaviors the care recipient has demonstrated at least one a week.

- ☐ Delusional
- ☐ Disruptive behavior
- ☐ Getting lost/wandering
- ☐ Impaired decision-making
- ☐ Memory deficit
- ☐ Physical aggression
- ☐ Verbal disruption
- ☐ Not applicable

Title : _____ Date

Title : _____ Date

DAAS Caregiver Assessment

What is your immediate need as a caregiver?

1. At the present time please rate your emotional health If **fair** or **poor**, how does this affect you?	Excellent	Good	Fair	Poor
2. Overall, how stressed do you feel in caring for the care receiver?	Not stressed	Somewhat		Very stressed
3. Do you have an illness or any limitations that affect your ability to provide caregiving? If yes, please explain:			Yes	No
4. Do you have any financial responsibilities related to the cost of care for the care receiver? If **yes**, does this cause any problems for you? Explain:			Yes	No
5. Are there medications, supplies or treatments that either you and/or the care receiver should have, but cannot afford to buy? If yes, please explain:			Yes	No
6. Is anyone available to provide respite (relief) when you are unable to provide care? If **yes**, is such assistance available on short notice? Explain:			Yes	No

Please list the other people who are available to assist with care and/or provide respite (relief) when you are unable to provide care. These should be informal (non-paid) supports.

Name	Phone	Relationship to care receiver	Help Provided

7. Do you experience difficulties because of certain behaviors or needs of the care receiver, such as:	Often	Sometimes	Rarely	Never
Inappropriate shouting/ Verbally aggressive				
Sexually aggressive/Sexual gestures or other inappropriate behaviors				
Physically aggressive				
Memory problems or trouble understanding others				
Wandering off				
Repeating self				
Uncooperative				
In need of much attention				
Other situations				
How does this affect you?				

It's important that you acknowledge your own need for support, information and assistance.	Yes	No
8. Do you participate in a support or education group where you can discuss your feelings? If **Yes,** what type of group/frequency of attendance? If **No,** are you interested in participating in a support or education group? ☐Yes ☐No	☐	☐
9. Does the fact that where you live (rural, small town, suburban, or urban area) create any problems with your caregiving role? If **yes**, please explain	☐	☐
10. What additional skills and abilities do you need to perform the necessary tasks to provide care for the care receiver?	☐	☐

Place Unique Client Identifier Here

Pre-Outcome Measures Questions

Please help our agency improve services by answering the following questions. Your answers will be kept confidential. Please indicate if your knowledge is **Excellent**, **Good**, **Fair**, or **Poor**. **Fill in the circle** which best describes your answer. Thank you!

	Excellent (4)	Good (3)	Fair (2)	Poor (1)	N/A (0)
1. At the present time, please rate your physical health.	O	O	O	O	O
2. What is the likelihood the care receiver will be placed in a long-term care facility at this time?	O	O	O	O	O
3. How knowledgeable are you about the care receiver's condition?	O	O	O	O	O
4. Ability to perform the necessary tasks to provide care to the care receiver at home?	O	O	O	O	O
5. Care for wounds/drains/surgical sites, etc?	O	O	O	O	O
6. Ability to administer medications correctly.	O	O	O	O	O
7. Transfer techniques (moving from bed to chair, etc)?	O	O	O	O	O
8. Use of grab bars, shower chairs, and other devices?	O	O	O	O	O
9. Adult day care?	O	O	O	O	O
10. Adult Protective Services (APS)?	O	O	O	O	O
11. Assisted living?	O	O	O	O	O
12. Education and training?	O	O	O	O	O
13. Financial assistance?	O	O	O	O	O
14. Hospice?	O	O	O	O	O
15. In-home care?	O	O	O	O	O
16. Legal assistance?	O	O	O	O	O
17. Light housekeeping services?	O	O	O	O	O
18. Meals on Wheels?	O	O	O	O	O
19. Medical devices?	O	O	O	O	O
20. Medication management equipment?	O	O	O	O	O
21. Nursing home?	O	O	O	O	O

22. Ombudsman?	O	O	O	O	O
23. Overnight respite?	O	O	O	O	O
24. Personal Care?	O	O	O	O	O
25. Senior Centers?	O	O	O	O	O
26. Senior Companion?	O	O	O	O	O
27. Support Groups?	O	O	O	O	O
28. Transportation?	O	O	O	O	O
29. VA information?	O	O	O	O	O

Pre Strain Index	Yes	No
30. Sleep is disturbed (e.g. because care receiver is in and out of bed or wanders during the night)	O	O
31. It is inconvenient (e.g. because helping takes so much time or it's a long drive to help)	O	O
32. It is a physical strain (e.g. because of lifting in and out of chair; effort or concentration is required)	O	O
33. It is confining (e.g. helping restrict free time or cannot go visiting)	O	O
34. There have been family adjustment (e.g. because helping has disrupted routine/ there has been no privacy)	O	O
35. There have been changes in personal plans (e.g. had to turn down a job; could not go on vacation	O	O
36. There have been other demands on my time (e.g. from other family members)	O	O
37. There have been emotional adjustments (e.g. because of severe arguments)	O	O
38. Some behavior is upsetting (e.g. because of incontinence; care receiver has trouble remembering things or accuses people of taking things)	O	O
39. It is upsetting to find care receiver has changed so much from his/her former self (e.g. he/she is a different person than he/she used to be)	O	O
40. There have been work adjustments (e.g. because of having to take time off)	O	O
41. It is a financial strain	O	O
42. Feeling completely overwhelmed (e.g. because of worry about care receiver; concerns about how you will manage)	O	O
43. Have you had a preventative medical exam in the past six months?	O	O

Place Unique Client Identifier Here

Client Signature	Date
Case Manager Signature	Date

Case Manager Notes/Thoughts/Observations:

Best Practices
Advanced Directives Checklist

Note to Case Manager: Caregivers often have difficult decisions to make on behalf of their care receivers. Asking the following questions regarding legal issues and end of life wishes can help people identify the issues that need to be addressed and communicated with others. Just having advance directive forms filled out will not be effective if there hasn't been informed, thoughtful reflection about their wishes. It is also helpful if the caregiver is aware of these wishes and is informed about where these written documents are located before crisis occurs. Please check any of the following that apply:

	Yes	No
Do you have a legal guardian		
Name: Phone #:		
Do you have a power of attorney for finances?		
Can you locate the information		
Do you have Advance Health Care Directives?		
Can you locate the information		
Do you have a medical treatment plan?	☐	☐
Can you locate the information	☐	☐
Do you have Emergency Medical Services (EMS)/Do Not Resuscitate (DNR) directives?	☐	☐
Can you locate the information	☐	☐
Do you have a funeral plan?	☐	☐
Can you locate the information	☐	☐
Do you have a burial plan?	☐	☐
Can you locate the information		

Case Manager Recommendations:

☐

☐ ☐
☐ ☐
☐ ☐
☐ ☐
☐ ☐
☐ ☐

_____ _____

Case Manager Date

Best Practices

OPTIONAL

Case Managers: Please make extra copies of this form to leave with client. Discuss appropriate services and resources with caregiver. *Check the services/resources that would be most useful to them and which ones they would like to receive if they were available.*

If it were possible to have access to any of the following services/resources in your area, which ones would be most useful in your caregiving role?

Possible Services/Resources	CG	CR	Is service available	Possible Services/Resources	CG	CR	Is service available
General:				**Long-Term Care:**			
Information about available services				Help in considering options			
Assistance in accessing services				Help with admitting to a facility			
Counseling/Support/Training				Housing assistance/Assisted living			
Case management				Hospice services			
In-Home Care/Assistance:				LTC insurance			
Training for special tasks you do				**Other Services/Resources:**			
Homemaker services				Prescription assistance (financial)			
OT/PT for care receiver				Nutrition counseling & Supplements			
ERS/Support for emergencies				MOW/Food pantry			
Help in organizing services, training or support workers				Information on adult protective services			
Specialist/Medical services				Link with your faith community			
Respite Care/Socialization:				Transportation			
In-home respite care				Legal/Financial			
Overnight respite				Equipment/Home modifications			
Senior center				Information on Medicaid/Medicare			
Adult day center							
Companion program/volunteers							
Other (specify)				**Other (specify)**			

Case Manager Recommendations:

_____ _____

Case Manager Date

Best Practices

OPTIONAL

Do you have any concerns about safety for your care receiver? ☐Yes ☐No
Does your living or housing arrangements cause any difficulties? ☐Yes ☐No

Safety and Home Modification Checklist: (please check all that apply) **Please make extra copies of this form to leave with client.**

Bathroom:
___ Grab bars or safety rails for support when getting in/out of tub/shower
___ Apply non-slip strips on bathtub and shower floors
___ Use bathmats and rugs with non-skid backings
___ Use an adjustable-height shower seat rather than standing (if necessary)
___ Install an adjustable-height or handheld showerhead
___ Turn down the water temperature on the hot water heater to 120 degrees to prevent scalding
___ Consider a raised toilet seat or grab bar to make getting up and down easier
___ Avoid locking the bathroom door when bathing to allow quicker access if necessary

Bedroom:
___ Widen or clear pathways through the bedroom – arrange furniture to create open space
___ Make sure all electrical cords have been cleared from paths
___ Place smoke and carbon monoxide detectors outside of bedrooms on each level of the home
___ Keep a phone with a cord within easy reach of the bed
___ Post a list of emergency numbers near the phone
___ Secure rug edges with double-sided tape or remove scatter rugs
___ Make sure you can switch on a lamp before leaving bed to illuminate the path
___ Carry a cordless phone with you if you feel unstable when you get out of bed
___ Consider using risers to elevate your bed if it is too close to the floor and makes it difficult to get up

Kitchen:
___ Don't wear loose sleeves when cooking
___ Use a timer when cooking or baking so you don't forget that something is cooking
___ Consider a long handled dustpan/broom combination to reduce bending
___ If you use a rug on the floor in front of the sink, use a rubber-backed mat
___ If you can't read the stove/oven knobs, investigate large-sized controls through vision support organizations
___ Install cupboard door handles that are easy to grasp;, such as D-type handles
___ Store frequently used items in easy-to-reach cabinets and on countertops
___ Increase kitchen lighting over task areas such as countertops, stove, and sink
___ Have a seated workspace available
___ Create a safe place to rest hot food immediately as you remove it from the microwave

Living Room and Throughout the Home
___ Increase lighting at entryways
___ Leave lights on if you walk through the house after dark or use motion sensor lighting fixtures
___ Change to lever-type door handles if knobs are difficult to grasp or manipulate
___ Install no-step, no-trip thresholds at doorways
___ Install peepholes on exterior doors that are the right height for the homeowner
___ Install handles and locks on all windows that are easy to grip at the right height
___ Make sure all railings are sturdy and that handrails are on both sides of all stairs
___ Secure all rug edges with double-sided tape or consider removing them
___ Create visual contrast in stairs risers with paint or tape if vision problems are a concern
___ Make sure homeowners can see and use climate controls for heating and air conditioning

Notes:

*This is only a partial list and all items will not apply to every client. Consider consulting with an occupational therapist to consider each person's environment. This list was created by members of the Occupational Therapy Association of California.

Place Unique Client Identifier Here

Post-Outcome Measures Questions

Please help our agency improve services by answering the following questions. Your answers will be kept confidential. Please indicate if your knowledge is **Excellent**, **Good**, **Fair**, or **Poor**. **Fill in the circle** which best describes your answer. Thank you!

	Excellent (4)	Good (3)	Fair (2)	Poor (1)	N/A (0)
1. At the present time, please rate your physical health.	O	O	O	O	O
2. What is the likelihood the care receiver will be placed in a long-term care facility at this time?	O	O	O	O	O
3. How knowledgeable are you about the care receiver's condition?	O	O	O	O	O
4. Ability to perform the necessary tasks to provide care to the care receiver at home?	O	O	O	O	O
5. Care for wounds/drains/surgical sites, etc?	O	O	O	O	O
6. Ability to administer medications correctly.	O	O	O	O	O
7. Transfer techniques (moving from bed to chair, etc)?	O	O	O	O	O
8. Use of grab bars, shower chairs, and other devices?	O	O	O	O	O
9. Adult day care?	O	O	O	O	O
10. Adult Protective Services (APS)?	O	O	O	O	O
11. Assisted living?	O	O	O	O	O
12. Education and training?	O	O	O	O	O
13. Financial assistance?	O	O	O	O	O
14. Hospice?	O	O	O	O	O
15. In-home care?	O	O	O	O	O
16. Legal assistance?	O	O	O	O	O
17. Light housekeeping services?	O	O	O	O	O
18. Meals on Wheels?	O	O	O	O	O
19. Medical devices?	O	O	O	O	O
20. Medication management equipment?	O	O	O	O	O
21. Nursing home?	O	O	O	O	O

Post Strain

22. Ombudsman?	O	O	O	O	O
23. Overnight respite?	O	O	O	O	O
24. Personal Care?	O	O	O	O	O
25. Senior Centers?	O	O	O	O	O
26. Senior Companion?	O	O	O	O	O
27. Support Groups?	O	O	O	O	O
28. Transportation?	O	O	O	O	O
29. VA information?	O	O	O	O	O

Post Strain Index	Yes	No
30. Sleep is disturbed (e.g. because care receiver is in and out of bed or wanders during the night)	O	O
31. It is inconvenient (e.g. because helping takes so much time or it's a long drive to help)	O	O
32. It is a physical strain (e.g. because of lifting in and out of chair; effort or concentration is required)	O	O
33. It is confining (e.g. helping restrict free time or cannot go visiting)	O	O
34. There have been family adjustment (e.g. because helping has disrupted routine/ there has been no privacy)	O	O
35. There have been changes in personal plans (e.g. had to turn down a job; could not go on vacation	O	O
36. There have been other demands on my time (e.g. from other family members)	O	O
37. There have been emotional adjustments (e.g. because of severe arguments)	O	O
38. Some behavior is upsetting (e.g. because of incontinence; care receiver has trouble remembering things or accuses people of taking things)	O	O
39. It is upsetting to find care receiver has changed so much from his/her former self (e.g. he/she is a different person than he/she used to be)	O	O
40. There have been work adjustments (e.g. because of having to take time off)	O	O
41. It is a financial strain	O	O
42. Feeling completely overwhelmed (e.g. because of worry about care receiver; concerns about how you will manage)	O	O
43. Have you had a preventative medical exam in the past six months?	O	O

Place Unique Client Identifier Here

NAPIS/DAAS Caregiver Intake

TOTAL RISK SCORE	

1. Agency:			2. Date of Intake:
3. Intake Worker:			
4. How did you learn about our services?			
5. Last Name:	6. First:	7. M.I.:	8. Preferred Name:
9. Street Address/PO Box:			10. Apartment/Unit#:
11. City:	12. County:	13. State: 14. Zip:	15. Telephone (H): (C): (W):
16. Email:		17. Gender: Male Female	18. DOB:
19. Alternate Contact Name:		20. Alternate Contact Telephone:	
21. Medical Condition:			

22. Current Living Arrangement: Lives Alone With others Spouse/Partner Spouse & child Child/Grandchildren	23. Marital Status: Single Married Widowed Divorced Separated	24. Persons in family/household: 1 2 3 4 5 6 7 8 plus
25. Veteran: Yes No If yes, have you applied for Veterans' assistance? Yes No	26. Current employment status: Full-time Not Employed Part-time Retired Volunteer	27. Are you below poverty level? _____ Yes No Not Answered
28. Is funding for professional help a concern? Yes No	29. Primary language spoken at home: _____ Do you need an interpreter? Yes No	30. Ethnicity: Hispanic or Latino Not Hispanic or Latino
31. Race: American Indian or Alaskan Native Asian Black or African American Native Hawaiian or Pacific Islander White	32. Rural? Yes No 33. What prompted your call?	

34. Length of time you have been a primary caregiver for this person:				
35. In the last five weeks, have there been changes that have made your situation more difficult? Describe changes?			Yes (1)	No (0)
36. Will there be a change or temporary situation in the near future that will impact care?			Yes (1)	No (0)
37. Are you the only person involved in the caregiving on a regular basis?			Yes (1)	No (0)
38. Do you have any of the following demands on your time and energy?				
a. Employed **full-time** or **part-time**			Yes (1)	No (0)
b. Minor children at home			Yes (1)	No (0)
c. Caring for a person with a severe disability			Yes (1)	No (0)
d. Raising a grandchild			Yes (1)	No (0)
e. Raising a grandchild with a DD/MR diagnosis			Yes (1)	No (0)
f. Caring for a second care receiver			Yes (1)	No (0)
g. Does the caregiver have significant memory impairment?			Yes (5)	No (0)
h. Does the care receiver have significant memory impairment?			Yes (5)	No (0)
39. How stressed do you feel as a caregiver?	Very (2)	Somewhat (1)	Not at all (0)	
40. Have you received respite or supplemental services from the UCSP in the last 12 months?			Yes (0)	No (10)
41. If **yes**, did you find alternative/replacement services to meet the care receiver's needs when services ended?			Yes (0)	No (10)
42. Is there an APS supported finding for abuse, neglect, or exploitation? If **Yes**, date referral made:			Yes (5)	No (0)
43. Do you feel you are at risk for abuse, neglect, self-neglect, or exploitation? (no score)			Yes (0)	No (0)
44. Is the care receiver at risk of abuse, neglect, self-neglect, or exploitation? (no score)			Yes (0)	No (0)
45. How many times per week do you get away from the caregiving situation (not counting employment)?	Never (3)	1-3 (2)	4-6 (1)	7+ (0)
46. How many hours a week do you get away from the caregiving situation (not counting employment)?	Never (3)	1-2 (2)	3-5 (1)	6-8 (0)
Total Scored Caregiver Questions				

The Caregiver Strain Index		
I am going to read a list of things that other people have found to be difficult. Would you tell me if any of these apply to you? (give examples)		
1. Sleep is disturbed (e.g., because _____is in and out of bed or wanders around at night)	Yes (1)	No (0)
2. It is inconvenient (e.g., because helping takes so much time or it's a long drive over to help)	Yes (1)	No (0)
3. It is a physical strain (e.g., because of lifting in and out of chair; effort or concentration is required)	Yes (1)	No (0)
4. It is confining (e.g., helping restrict free time or cannot go visiting)	Yes (1)	No (0)
5. There have been family adjustments (e.g., because helping has disrupted routine; there has been no privacy)	Yes (1)	No (0)
6. There have been changes in personal plans (e.g., had to turn down a job; could not go on vacation)	Yes (1)	No (0)
7. There have been other demands on my time (e.g., from other family members)	Yes (1)	No (0)
8. There have been emotional adjustments (e.g., because of severe arguments)	Yes (1)	No (0)
9. Some behavior is upsetting (e.g., because of incontinence; _____has trouble remembering things; or _____accuses people of taking things)	Yes (1)	No (0)
10. It is upsetting to find _____has changed so much from his/her former self (e.g., he/she is a different person than he/she used to be)	Yes (1)	No (0)
11. There have been work adjustments (e.g., because of having to take time off)	Yes (1)	No (0)
12. It is a financial strain	Yes (1)	No (0)
13. Feeling completely overwhelmed (e.g., because of worry about _____; concerns about how you will manage)	Yes (1)	No (0)
Total Score (count yes responses. Any positive answer may indicate a need for intervention in that area. A score of seven or higher indicates a high level of stress)		

Caregiver Activity Levels (ADL's)				
During the past seven days, how would you rate your ability to perform the following:	Independent (0)	Supervision (1)	Requires Assistance (2)	Dependent (3)
Bathing (include shower, full tub or sponge bath/exclude washing back, or hair)?				
Dressing?				
Toilet use?				
Ability to walk about in your own home?				
Your ability to eat?				
Your ability to transfer?				
Subtotal:				
TOTAL ADL SCORE				

Caregiver Activity Levels (IADL's)				
During the past seven days, how would you rate your ability to perform the following:	Independent (0)	Supervision (1)	Requires Assistance (2)	Dependent (3)
Meal preparation?				
Manage medications?				
Manage money?				
Heavy housework?				
Light housekeeping?				
Shopping?				
Transportation?				
Use the telephone?				
Subtotal:				
TOTAL IADL SCORE				

Care Receiver

Care Receiver Last Name:	Alternate Contact Name:
Care Receiver First Name:	Alternate Contact Phone:
DOB:	How did you learn about our services?
Address:	
Medical Condition:	How are you related to the care receiver? (I am their…) Husband Wife Non-Relative Daughter/Daughter-In-Law Son/Son-In-Law Grandparent Grandparent Raising a Grandchild Other Elderly Non-Relative Other Elderly Relative Grandchild Other

Care Receiver Activity Levels (ADL's)				
During the past seven days, how would you rate your ability to perform the following:	Independent (0)	Supervision (1)	Requires Assistance (2)	Dependent (3)
Bathing (include shower, full tub or sponge bath/exclude washing back, or hair)?				
Dressing?				
Toilet use?				
Ability to walk about in your own home?				
Your ability to eat?				
Your ability to transfer?				
Subtotal:				
TOTAL ADL SCORE				

Care Receiver Activity Levels (IADL's)				
During the past seven days, how would you rate your ability to perform the following:	Independent (0)	Supervision (1)	Requires Assistance (2)	Dependent (3)
Meal preparation?				
Manage medications?				
Manage money?				
Heavy housework?				
Light housekeeping?				
Shopping?				
Transportation?				
Use the telephone?				
Subtotal:				
TOTAL IADL SCORE				

Comments:

Caregiver Questions			
Caregiver Strain Index			
Caregiver ADLs			
Caregiver IADLs			
Care Receiver ADLs			
Care Receiver IADLs			
TOTAL RISK SCORE			

Score Range
Low = 0-46
Moderate = 47-92
High = 93+

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT

Date Screen: __ / __ / __
Assessment: __ / __ / __
Reassessment: __ / __ / __

1 IDENTIFICATION/BACKGROUND

Name & Vital Information

Client Name: _____ Client SSN: _____
(Last) (First) (Middle Initial)

Address: _____
(Street) (City) (State) (Zip Code)

Phone: _____ City/County Code: _____

Directions to House:

Pets?

Demographics

Birthdate: ____ / ____ / ____ **Age:** _____ **Sex:** ____ Male 0 ____ Female 1
(Month) (Day) (Year)

Marital Status: ____ Married 0 ____ Widowed 1 ____ Separated 2 ____ Divorced 3 ____ Single 4 ____ Unknown 9

Race:
____ White 0
____ Black/African American 1
____ American Indian 2
____ Oriental/Asian 3
____ Alaskan Native 4
____ Unknown 9 _____

Education:
____ Less than High School 0
____ Some High School 1
____ High School Graduate 2
____ Some College 3
____ College Graduate 4
____ Unknown 9

Communication of Needs:
____ Verbally, English 0
____ Verbally, Other Language 1
Specify: _____
____ Sign Language / Gestures / Device 2
____ Does Not Communicate 3
Hearing Impaired? ____

Ethnic Origin: _____ Specify: _____

Primary Caregiver/Emergency Contact/Primary Physician

Name: _____ **Relationship:** _____

Address: _____ **Phone:** (H) _____ (W) _____

Name: _____ **Relationship:** _____

Address: _____ **Phone:** (H) _____ (W) _____

Name of Primary Physician: _____ **Phone:** _____

Address: _____

Initial Contact

Who called: _____
(Name) (Relation to Client) (Phone)

Presenting Problem/Diagnosis:

CLIENT NAME:	Client SSN:

Current Formal Services

Do you currently use any of the following types of services?

No 0	Yes 1	*Check All Services That Apply*	**Provider/Frequency:**
		Adult Day Care	
		Adult Protective	
		Case Management	
		Chore/Companion/Homemaker	
		Congregate Meals/Senior Center	
		Financial Management/Counseling	
		Friendly Visitor/Telephone Reassurance	
		Habilitation/Supported Employee	
		Home Delivered Meals	
		Home Health/Rehabilitation	
		Home Repairs/Weatherization	
		Housing	
		Legal	
		Mental Health (Inpatient/Outpatient)	
		Mental Retardation	
		Personal Care	
		Respite	
		Substance Abuse	
		Transportation	
		Vocational Rehab/Job Counseling	
		Other: _____	

Financial Resources

Where are you on the scale for annual (monthly) family income before taxes?

_____	$20,000 or More	($1,667 or More) 0
_____	$15,000 - 19,999	($1,250 - $1,666) 1
_____	$11,000 - 14,999	($ 917 - $1,249) 2
_____	$ 9,500 - 10,999	($ 792 - $ 916) 3
_____	$ 7,000 - 9,499	($ 583 - $ 791) 4
_____	$ 5,500 - 6,999	($ 458 - $ 582) 5
_____	$ 5,499 or Less	($ 457 or Less) 6
_____	Unknown 9	

Number in Family unit: _____

Optional: Total monthly family income: _____

Do you currently receive income from…?

No 0	Yes		*Optional: Amount*
		Black Lung,	
		Pension,	
		Social Security,	
		SSI / SSDI,	
		VA Benefits,	
		Wages / Salary,	
		Other,	

Does anyone cash your check, pay your bills or manage your business?

No 0	Yes 1		***Names***
		Legal Guardian,	
		Power of Attorney,	
		Representative Payee,	
		Other,	

Do you receive any benefits or entitlements?

No 0	Yes 1	
		Auxiliary Grant
		Food Stamps
		Fuel Assistance
		General Relief
		State and Local Hospitalization
		Subsidized Housing
		Tax Relief

What types of health insurance do you have?

No 0	Yes 1		
		Medicare, #	
		Medicaid, #	
		Pending: ☐ No 0 ☐ Yes 1	
		QMB/SLMB: ☐ No 0 ☐ Yes 1	
		All Other Public / Private:	

CLIENT NAME:	Client SSN:

Physical Environment

Where do you usually live? Does anyone live with you?

	Alone 1	Spouse 2	Other 3	Names of Persons in Household
____ House: Own 0				
____ House: Rent 1				
____ House: Other 2				
____ Apartment 3				
____ Rented Room 4				

	Name of Provider (Place)	Admission Date	Provider Number (If Applicable)
____ Adult Care Residence 50			
____ Adult Foster 60			
____ Nursing Facility 70			
____ Mental Health/ Retardation Facility 80			
____ Other 90			

Where you usually live, are there any problems?

No 0	Yes 1	*Check All Problems That Apply*
____	____	Barriers to Access
____	____	Electrical Hazards
____	____	Fire Hazards / No Smoke Alarm
____	____	Insufficient Heat / Air Conditioning
____	____	Insufficient Hot Water / Water
____	____	Lack of / Poor Toilet Facilities (Inside/Outside)
____	____	Lack of / Defective Stove, Refrigerator, Freezer
____	____	Lack of / Defective Washer / Dryer
____	____	Lack of / Poor Bathing Facilities
____	____	Structural Problems
____	____	Telephone Not Accessible
____	____	Unsafe Neighborhood
____	____	Unsafe / Poor Lighting
____	____	Unsanitary Conditions
____	____	Other: ____

Describe Problems:

CLIENT NAME:	Client SSN:

2 FUNCTIONAL STATUS (Check only one block for each level of functioning)

ADLS	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 Human Help		MH & HH 3		Performed by Others 40			Is Not Performed 50
	No 00	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2				
Bathing											
Dressing											
Toileting											
Transferring											
								Spoon Fed 1	Syringe/ Tube Fed 2	Fed by IV 3	
Eating / Feeding											

Continence	Needs Help?		Incontinent Less than weekly 1	External Device/ Indwelling/ Ostomy Self care 2	Incontinent Weekly or more 3	External Device Not self care 4	Indwelling Catheter Not self care 5	Ostomy Not self care 6
	No 00	Yes						
Bowel								
Bladder								

Comments:

Ambulation	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 Human Help		MH & HH 3		Performed by Others 40	Is Not Performed 50
	No 00	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		
Walking									
Wheeling									
Stairclimbing									
								Confined Moves About	Confined Does Not Move About
Mobility									

IADLS	Needs Help?	
	No 0	Yes 1
Meal Preparation		
Housekeeping		
Laundry		
Money Management		
Transportation		
Shopping		
Using Phone		
Home Maintenance		

Comments:

Outcome: Is this a short assessment?

_____ No, Continue with **Section** 3 0 _____ Yes, Service Referrals 1 _____ Yes, No Service Referrals 2

Screener: _____ **Agency:** _____

CLIENT NAME:	Client SSN:

3 PHYSICAL HEALTH ASSESSMENT

Professional Visits/Medical Admissions

Doctor's Name(s) *(List all)*	Phone	Date of Last Visit	Reason for Last Visit

Admission: In the past 12 months have, you been admitted to a . . . for medical or rehabilitation reasons?

No 0	Yes 1		Name of Place	Admit Date	Length of Stay/Reason
		Hospital			
		Nursing Facility			
		Adult Care Residence			

Do you have any advance directives such as . . . (Who has it…Where is it…)**?**

No 0 Yes 1 *Location*

_____ _____ Living Will, _____

_____ _____ Durable Power of Attorney for Health Care, _____

_____ _____ Other, _____

Diagnoses & Medication Profile

Do you have any current medical problems, or a known or suspected diagnosis of mental retardation or related conditions, such as . . . (Refer to the list of diagnoses)**?**

Current Diagnoses **Date of Onset**

_____

_____

_____

_____

_____

_____

Enter Codes for 3 Major, Active Diagnoses: _____ None 00 _____ DX1 _____ DX2 _____ DX3

	Current Medications (Include Over-the-Counter)	**Dose, Frequency, Route**	**Reason(s) Prescribed**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Total No. of Medications: _____ (If 0, skip to Sensory Function) **Total No. of Tranquilizer/Psychotropic Drugs:** _____

Do you have any problems with medicine(s)…?

No 0 Yes 1

_____ _____ Adverse reactions / allergies

_____ _____ Cost of medication

_____ _____ Getting to the pharmacy

_____ _____ Taking them as instructed / prescribed

_____ _____ Understanding directions / schedule

How do you take your medications?

_____ Without assistance 0

_____ Administered / monitored by lay person 1

_____ Administered / monitored by professional nursing staff 2

Describe help: _____

Name of helper: _____

Diagnoses:
Alcoholism/Substance Abuse (01)
Blood-Related Problems (02)
Cancer (03)
Cardiovascular Problems
Circulation (04)
Heart Trouble (05)
High Blood Pressure (06)
Other Cardiovascular Problems (07)
Dementia
Alzheimer's (08)
Non-Alzheimer's (09)
Developmental Disabilities
Mental Retardation (10)
Related Conditions
Autism (11)
Cerebral Palsy (12)
Epilepsy (13)
Friedreich's Ataxia (14)
Multiple Sclerosis (15)
Muscular Dystrophy (16)
Spina Bifida (17)
Digestive/Liver/Gall Bladder (18)
Endocrine (Gland) Problems
Diabetes (19)
Other Endocrine Problems (20)
Eye Disorders (21)
Immune System Disorders (22)
Muscular/Skeletal
Arthritis/Rheumatoid Arthritis (23)
Osteoporosis (24)
Other Muscular/Skeletal Problems (25)
Neurological Problems
Brain Trauma/Injury (26)
Spinal Cord Injury (27)
Stroke (28)
Other Neurological Problems (29)
Psychiatric Problems
Anxiety Disorder (30)
Bipolar (31)
Major Depression (32)
Personality Disorder (33)
Schizophrenia (34)
Other Psychiatric Problems (35)
Respiratory Problems
Black Lung (36)
COPD (37)
Pneumonia (38)
Other Respiratory Problems (39)
Urinary/Reproductive Problems
Renal Failure (40)
Other Urinary/Reproductive Problems (4
All Other Problems (42)

CLIENT NAME:	Client SSN:

Sensory Functions

How is your vision, hearing, and speech?

	No Impairment 0	Impairment Record Date of Onset/Type of Impairment		Complete Loss 3	Date of Last Exam
		Compensation 1	No Compensation 2		
Vision					
Hearing					
Speech					

Physical Status

Joint Motion: How is your ability to move your arms, fingers and legs?

_____ Within normal limits or instability corrected 0
_____ Limited motion 1
_____ Instability uncorrected or immobile 2

Have you ever broken or dislocated any bones . . . Ever had an amputation or lost any limbs . . . Lost voluntary movement of any part of your body?

Fractures/Dislocations	Missing Limbs	Paralysis/Paresis
____ None 000	____ None 000	____ None 000
____ Hip Fracture 1	____ Finger(s)/Toe(s) 1	____ Partial 1
____ Other Broken Bone(s) 2	____ Arm(s) 2	____ Total 2
____ Dislocation(s) 3	____ Leg(s) 3	Describe: _____
____ Combination 4	____ Combination 4	
Previous Rehab Program?	**Previous Rehab Program?**	**Previous Rehab Program?**
____ No/Not Completed 1	____ No/Not Completed 1	____ No/Not Completed 1
____ Yes 2	____ Yes 2	____ Yes 2
Date of Fracture/Dislocation?	**Date of Amputation?**	**Onset of Paralysis?**
____ 1 Year or Less 1	____ 1 Year or Less 1	____ 1 Year or Less 1
____ More than 1 Year 2	____ More than 1 Year 2	____ More than 1 Year 2

Nutrition

Height: _____ (inches) **Weight:** _____ (lbs.) **Recent Weight Gain/Loss:** _____ **No 0** _____ **Yes 1**
Describe: _____

Are you on any special diet(s) for medical reasons?

____ None 0
____ Low Fat / Cholesterol 1
____ No / Low Salt 2
____ No / Low Sugar 3
____ Combination / Other 4

Do you take dietary supplements?

____ None 0
____ Occasionally 1
____ Daily, Not Primary Source 2
____ Daily, Primary Source 3
____ Daily, Sole Source 4

Do you have any problems that make it hard to eat?

No 0	Yes 1	
____	____	Food Allergies
____	____	Inadequate Food / Fluid Intake
____	____	Nausea / Vomiting / Diarrhea
____	____	Problems Eating Certain Foods
____	____	Problems Following Special Diets
____	____	Problems Swallowing
____	____	Taste Problems
____	____	Tooth or Mouth Problems
____	____	Other: _____

CLIENT NAME:	Client SSN:

Current Medical Services

Rehabilitation Therapies: Do you get any therapy prescribed by a doctor, such as …?

No 0	Yes 1		*Frequency*
____	____	Occupational	____
____	____	Physical	____
____	____	Reality/Remotivation	____
____	____	Respiratory	____
____	____	Speech	____
____	____	Other	____

Do you have pressure ulcers?

		Location/Size
____	None 0	
____	Stage I 1	____
____	Stage II 2	____
____	Stage III 3	____
____	Stage IV 4	____

Special Medical Procedures: Do you receive any special nursing care, such as …?

No 0	Yes 1		*Site, Type, Frequency*
____	____	Bowel/Bladder Training	____
____	____	Dialysis	____
____	____	Dressing/Wound Care	____
____	____	Eyecare	____
____	____	Glucose/Blood Sugar	____
____	____	Infections/IV Therapy	____
____	____	Oxygen	____
____	____	Radiation/Chemotherapy	____
____	____	Restraints (Physical/Chemical)	____
____	____	ROM Exercise	____
____	____	Trach Care/Suctioning	____
____	____	Ventilator	____
____	____	Other:	____

Medical/Nursing Needs

Based on client's overall condition, assessor should evaluate medical and/or nursing needs.

Are there ongoing medical/nursing needs? ____ No 0 ____ Yes 1

If yes, describe ongoing medical/nursing needs:

1. Evidence of medical instability.
2. Need for observation/assessment to prevent destabilization.
3. Complexity created by multiple medical conditions.
4. Why client's condition requires a physician, RN, or trained nurse's aide to oversee care on a daily basis.

Comments:

Optional: Physician's Signature: ____ Date: ____

Others: ____ Date: ____
(Signature/Title)

CLIENT NAME:	Client SSN:

4 PSYCHO-SOCIAL ASSESSMENT

Cognitive Function

Orientation *(Note: Information in italics is optional and can be used to give a MMSE Score in the box to the right.)*

Person: **Please tell me your full name** (so that I can make sure our record is correct).
Place: **Where are we now** *(state, country, town, street/route number, street name/box number)?*
Give the client 1 point for each correct response.
Time: **Would you tell me the date today** *(year, season, date, day, month)***?**

_____ Oriented 0
_____ Disoriented – Some spheres, some of the time 1
_____ Disoriented – Some spheres, all the time 2
_____ Disoriented – All spheres, some of the time 3
_____ Disoriented – All spheres, all of the time 4
_____ Comatose 5

Spheres affected: _____

Recall/Memory/Judgment

Recall: **I am going to say three words, and I want you to repeat them after I am done** (House, Bus, Dog). ✪ Ask the client to repeat them. *Give the client 1 point for each correct response on the first trial.* ✪ Repeat up to 6 trials until client can name all 3 words. Tell the client to hold them in his mind because you will ask him again in a minute or so what they are.

Attention/ Concentration: *Spell the word "WORLD". Then ask the client to spell it backwards. Give 1 point for each correctly placed letter (DLROW).*

Short-Term: ✪ Ask the client to recall the 3 words he was to remember.

Long-Term: **When were you born** (What is your date of birth)**?**

Judgment: **If you needed help at night, what would you do?**

No 0	Yes 1	
_____	_____	Short-Term Memory Loss?
_____	_____	Long-Term Memory Loss?
_____	_____	Judgment Problems?

Optional: **MMSE Score**

_____ (5)
_____ (5)
_____ (3)
_____ (5)

Total: _____

Note: Score of 14 or below implies cognitive impairment

Behavior Pattern

Does the client ever wander without purpose (trespass, get lost, go into traffic, etc.) **or become agitated and abusive?**

_____ Appropriate 0
_____ Wandering / Passive – Less than weekly 1
_____ Wandering / Passive – Weekly or more 2
_____ Abusive / Aggressive / Disruptive – Less than weekly 3
_____ Abusive / Aggressive / Disruptive – Weekly or more 4
_____ Comatose 5

Type of inappropriate behavior: _____ Source of Information: _____

Life Stressors

Are there any stressful events that currently affect your life, such as . . . ?

No 0	Yes 1		No 0	Yes 1		No 0	Yes 1	
____	____	Change in work/employment	____	____	Financial problems	____	____	Victim of a crime
____	____	Death of someone close	____	____	Major illness - family/friend	____	____	Failing health
____	____	Family conflict	____	____	Recent move/relocation	____	____	Other: _____

CLIENT NAME:	Client SSN:

Emotional Status

In the past month, how often did you . . . ?	Rarely/ Never 0	Some of the Time 1	Often 2	Most of the Time 3	Unable to Assess 9
Feel anxious or worry constantly about things?					
Feel irritable, have crying spells or get upset over little things?					
Feel alone and that you don't have anyone to talk to?					
Feel like you didn't want to be around other people?					
Feel afraid that something bad was going to happen to you and/or feel that others were trying to take things from you or trying to harm you?					
Feel sad or hopeless?					
Feel that life is not worth living … or think of taking your life?					
See or hear things that other people did not see or hear?					
Believe that you have special powers that others do not have?					
Have problems falling or staying asleep?					
Have problems with your appetite … that is, eat too much or too little?					

Comments:

Social Status

Are there some things that you do that you especially enjoy?

No 0 Yes 1 *Describe*

_____ _____ Solitary Activities, _____

_____ _____ With Friends / Family, _____

_____ _____ With Groups / Clubs, _____

_____ _____ Religious Activities, _____

How often do you talk with your children family or friends either during a visit or over the phone?

Children	Other Family	Friends / Neighbors
_____ No Children 0	_____ No Other Family 0	_____ No Friends/Neighbors 0
_____ Daily 1	_____ Daily 1	_____ Daily 1
_____ Weekly 2	_____ Weekly 2	_____ Weekly 2
_____ Monthly 3	_____ Monthly 3	_____ Monthly 3
_____ Less than Monthly 4	_____ Less than Monthly 4	_____ Less than Monthly 4
_____ Never 5	_____ Never 5	_____ Never 5

Are you satisfied with how often you see or hear from your children, other family and/or friends?

_____ No 0 _____ Yes 1

CLIENT NAME:	Client SSN:

Hospitalization/Alcohol – Drug Use

Have you been hospitalized or received inpatient/outpatient treatment in the last 2 years for nerves, emotional/mental health, alcohol or substance abuse problems?

_____ No 0 _____ Yes 1

Name of Place	Admit Date	Length of Stay/Reason

Do (did) you ever drink alcoholic beverages?

_____ Never 0
_____ At one time, but no longer 1
_____ Currently 2
How much: _____
How often: _____

Do (did) you ever use non-prescription, mood altering substances?

_____ Never 0
_____ At one time, but no longer 1
_____ Currently 2
How much: _____
How often: _____

If the client has never used alcohol or other non-prescription, mood altering substances, skip to the tobacco question.

Have you, or someone close to you, ever been concerned about your use of alcohol/other mood altering substances?	Do (did) you ever use alcohol/other mood-altering substances with …	Do (did) you ever use alcohol/other mood-altering substances to help you …
_____ No 0 _____ Yes 1 **Describe concerns:** _____	No 0 Yes 1 _____ _____ Prescription drugs? _____ _____ OTC medicine? _____ _____ Other substances? **Describe what and how often:**	No 0 Yes 1 _____ _____ Sleep? _____ _____ Relax? _____ _____ Get more energy? _____ _____ Relieve worries? _____ _____ Relieve physical pain? **Describe what and how often:**

Do (did) you ever smoke or use tobacco products?

_____ Never 0
_____ At one time, but no longer 1
_____ Currently 2
How much: _____
How often: _____

Is there anything we have not talked about that you would like to discuss?

CLIENT NAME:	Client SSN:

5 ASSESSMENT SUMMARY

Indicators of Adult Abuse and Neglect: *While completing the assessment, if you suspect abuse, neglect or exploitation, you are required by Virginia law, Section 63.1-55.3, to report this to the local Department of Social Services, Adult Protective Services.*

Caregiver Assessment

Does the client have an informal caregiver?

_____ **No** 0 (Skip to Section on Preferences) _____ **Yes** 1

Where does the caregiver live?

_____ With client 0
_____ Separate residence, close proximity 1
_____ Separate residence, over 1 hour away 2

Is the caregiver's help . . .

_____ Adequate to meet the client's needs? 0
_____ Not adequate to meet the client's needs? 1

Has providing care to client become a burden for the caregiver?

_____ Not at all 0
_____ Somewhat 1
_____ Very much 2

Describe any problems with continued caregiving:

Preferences

Client's preference for receiving needed care: _____

_____

_____

Family/Representative's preference for client's care: _____

_____

_____

Physician's comments (if applicable)**:** _____

_____

_____

CLIENT NAME:	Client SSN:

Client Case Summary

Unmet Needs

No 0	Yes 1	(Check All That Apply)
___	___	Finances
___	___	Home / Physical Environment
___	___	ADLS
___	___	IADLS

No 0	Yes 1	(Check All That Apply)
___	___	Assistive Devices / Medical Equipment
___	___	Medical Care / Health
___	___	Nutrition
___	___	Cognitive / Emotional
___	___	Caregiver Support

Assessment Completed By:

Assessor's Name	Signature	Agency/Provider Name	Provider #	Section(s) Completed

Optional: Case assigned to: _____ Code #: _____

VT DAIL Full ILA11

VT DAIL Independent Living Assessment (Full ILA)

0A. Cover Sheet: INDIVIDUAL IDENTIFICATION

0. ILA is being completed for which (DAIL) program?

- ☐ A - Adult day
- ☐ B - ASP
- ☐ C - HASS
- ☐ D - Homemaker
- ☐ E - Medicaid Waiver (Choices for Care)
- ☐ F - AAA services (NAPIS)
- ☐ G - Other
- ☐ H - Dementia Respite

1. Date of assessment?

_____/_____/_____

2. Unique ID# for client.

_____

3.a. Client's last name?

_____

3.b. Client's first name?

_____

3.c. Client's middle initial?

_____

4. Client's telephone number.

_____

5. Client's Social Security Number?

_____-_____-_____

6. Client's date of birth?

_____/_____/_____

calculated age at assessment

7. Client's gender?

- ☐ M - Male
- ☐ F - Female
- ☐ T - Transgendered

8.a. Client's mailing street address or Post Office box.

_____

8.b. Client's mailing city or town.

_____

8.c. Client's mailing state.

_____

8.d. Client's mailing ZIP code.

_____

9.a. Residential street address or Post Office box.

_____

9.b. Residential city or town.

_____

9.c. Client's state of residence.

_____

9.d. Client's residential zip code.

_____

0B. Cover Sheet: ASSESSOR INFORMATION

1. Agency the assessor works for?

_____

2. ILA completed by? (name of assessor)

_____

0C. Cover Sheet: EMERGENCY CONTACT INFORMATION

1.a. Primary Emergency contact name?

_____

1.a.1. Primary Emergency contact relationship?

_____

1.b. Primary Emergency contact home phone?

_____

1.b.1. Primary Emergency contact work phone?

_____

1.c. Street address of Primary Emergency Contact?

_____

1.d. City or town of Primary Emergency Contact?

1.e. State of Primary Emergency Contact?

1.f. Zip code for Promary Emergency contact?

1.g. Emergency Contact #1's relationship to client

2.a. Name of Emergency Contact 2?

2.b. Phone number of the client's Emergency Contact #2?

2.c. Street address or P.O box of the client's emergency contact #2?

2.d. City or town of the client's emergency contact #2?

2.e. State of client's Emergency Contact #2?

2.f. ZIP code of the client's emergency contact #2?

3.a. Client's primary care physician?

3.b. Phone number for the client's primary care physician?

4. Does the client know what to do if there is an emergency?

- ☐ A - Yes
- ☐ B - No

5. In the case of an emergency, would the client be able to get out of his/her home safely?

- ☐ A - Yes
- ☐ B - No

6. In the case of an emergency, would the client be able to summon help to his/her home?

- ☐ A - Yes
- ☐ B - No

7. Does the client require immediate assistance from Emergency Services in a man-made or natural disaster?

- ☐ A - Yes
- ☐ B - No

8. Who is the client's provider for emergency response services?

9. Comments regarding Emergency Response

0D. Cover Sheet: DIRECTIONS TO CLIENT'S HOME

Directions to client's home.

1A. Intake: ASSESSMENT INFORMATION

1. Type of assessment

- ☐ A - Initial assessment
- ☐ B - Reassessment
- ☐ C - Update for Significant change in status assessment

2. Are there communication barriers for which you need assistance?

- ☐ A - Yes
- ☐ B - No

3. If yes, type of assistance?

4. Client's primary language.

- [ ] E - English
- [ ] L - American Sign Language
- [ ] F - French
- [ ] B - Bosnian
- [ ] G - German
- [ ] I - Italian
- [ ] S - Spanish
- [ ] P - Polish
- [ ] T - Portuguese
- [ ] M - Romanian
- [ ] R - Russian
- [ ] C - Other Chinese
- [ ] V - Vietnamese
- [ ] O - Other

4.a. Please specify or describe the client's primary language that is other than in the list.

1B. Intake: LEGAL REPRESENTATIVE

1.a. Does the client have an agent with Power of Attorney?

- [ ] A - Yes
- [ ] B - No

1.b. Name of client's agent with Power of Attorney?

1.c. Work phone number of the client's agent with Power of Attorney.

1.d. Home phone number of the client's agent with Power of Attorney.

2.a. Does the client have a Representative Payee?

- [ ] A - Yes
- [ ] B - No

2.b. Name of client's Representative Payee?

2.c. Work phone number of the client's Representative Payee.

2.d. Home phone number of the client's Representative Payee.

3.a. Does the client have a Legal Guardian?

- [ ] A - Yes
- [ ] B - No

3.b. Name of the client's Legal Guardian?

3.c. Work phone number of the client's Legal Guardian.

3.d. Home phone number of the client's Legal Guardian.

4.a. Does client have Advanced Directives for health care?

- [ ] A - Yes
- [ ] B - No

4.b. Name of agent for client's Advanced Directives?

4.c. Work phone number of the client's agent for Advanced Directives?

4.d. Home phone number of the client's agent for Advanced Directives.

4.e. If no Advanced Directives, was information provided about Advanced Directives?

- [ ] A - Yes
- [ ] B - No

1C. Intake: DEMOGRAPHICS

1. What is client's marital status?

- [ ] A - Single
- [ ] B - Married
- [ ] C - Civil union
- [ ] D - Widowed
- [ ] E - Separated
- [ ] F - Divorced
- [ ] G - Unknown

2a. What is client's race/ethnicity?

- [ ] A - Non-Minority (White, non-Hispanic)
- [ ] B - African American
- [ ] C - Asian/Pacific Islander (incl. Hawaiian)
- [ ] D - American Indian/Native Alaskan
- [ ] E - Hispanic Origin
- [ ] F - Unknown
- [ ] G - Other

2.G.Other. Enter the client's self-described ethnic background if OTHER

_____

2b. What is the client's Hispanic or Latino ethnicity? Choose one.

- [ ] A - Not Hispanic or Latino
- [ ] B - Hispanic or Latino
- [ ] C - Unknown

2c. What is the client's race? Choose multiple.

- [ ] A - Non-Minority (White, non-Hispanic)
- [ ] B - Black/African American
- [ ] C - Asian
- [ ] D - American Indian/Native Alaskan
- [ ] E - White-Hispanic
- [ ] F - Unknown
- [ ] H - Native Hawaiian/Other Pacific Islander
- [ ] G - Other

3. What type of residence do you live in?

- [ ] A - House
- [ ] B - Mobile home
- [ ] C - Private apartment
- [ ] D - Private apartment in senior housing
- [ ] E - Assisted Living (AL/RC with 24 hour supervision)
- [ ] F - Residential care home
- [ ] G - Nursing home
- [ ] H - Unknown
- [ ] I - Other

4. Client's Living arrangement? Who do you live with?

- [ ] A - Lives Alone
- [ ] B - Lives with others
- [ ] C - Dont know

5. Does the client reside in a rural area? Must answer yes for NAPIS

- [ ] A - Yes
- [ ] B - No

1D. Intake: HEALTH RELATED QUESTIONS: General

1. Were you admitted to a hospital for any reason in the last 30 days?

- [ ] A - Yes
- [ ] B - No

2. In the past year, how many times have you stayed overnight in a hospital?

- [ ] A - Not at all
- [ ] B - Once
- [ ] C - 2 or 3 times
- [ ] D - More than 3 times

3. Have you ever stayed in a nursing home, residential care home, or other institution? (including Brandon Training School and Vermont state Hospital)

- [ ] A - Yes
- [ ] B - No

4. Have you fallen in the past three months?

- [ ] A - Yes
- [ ] B - No

5. Do you use a walker or four prong cane (or equivalent), at least some of the time, to get around?

- [ ] A - Yes
- [ ] B - No

6. Do you use a wheelchair, at least some of the time, to get around?

- [ ] A - Yes
- [ ] B - No

7. In the past month how many days a week have you usually gone out of the house/building where you live?

- [ ] A - Two or more days a week
- [ ] B - One day a week or less

8. Do you need assistance obtaining or repairing any of the following? (Check all that apply)

- [ ] A - Eyeglasses
- [ ] B - Cane or walker
- [ ] C - Wheelchair
- [ ] D - Assistive feeding devices
- [ ] E - Assistive dressing devices
- [ ] F - Hearing aid
- [ ] G - Dentures
- [ ] H - Ramp
- [ ] I - Doorways widened
- [ ] J - Kitchen/bathroom modifications
- [ ] K - Other
- [ ] L - None of the above

1E. Intake: THE NSI DETERMINE Your Nutritional Health Checklist

1. Have you made any changes in lifelong eating habits because of health problems?

- [ ] A - Yes (Score = 2)
- [ ] B - No

2. Do you eat fewer than 2 meals per day?

- ☐ A - Yes (Score = 3)
- ☐ B - No

3. Do you eat fewer than five (5) servings (1/2 cup each) of fruits or vegetables every day?

- ☐ A - Yes (Score = 1)
- ☐ B - No

4. Do you eat fewer than two servings of dairy products (such as milk, yogurt, or cheese) every day?

- ☐ A - Yes (Score = 1)
- ☐ B - No

5. Do you have trouble eating due to problems with chewing/swallowing?

- ☐ A - Yes (Score = 2)
- ☐ B - No

6. Do you sometimes not have enough money to buy food?

- ☐ A - Yes (Score = 4)
- ☐ B - No

7. Do you eat alone most of the time?

- ☐ A - Yes (Score = 1)
- ☐ B - No

8. Do you take 3 or more different prescribed or over-the-counter drugs per day?

- ☐ A - Yes (Score = 1)
- ☐ B - No

9. Without wanting to, have you lost or gained 10 pounds or more in the past 6 months?

- ☐ A - Yes (Score = 2)
- ☐ B - No
- ☐ L - Yes, lost 10 pounds or more
- ☐ G - Yes, gained 10 pounds or more

10. Are there times when you are not always physically able to shop, cook and/or feed yourself (or to get someone to do it for you)?

- ☐ A - Yes (Score = 2)
- ☐ B - No

11. Do you have 3 or more drinks of beer, liquor or wine almost every day?

- ☐ A - Yes (Score = 2)
- ☐ B - No

What is the client's nutritional risk score?

12. Total score of Nutritional Risk Questions. Add the scores for all Yes answers for questions 1 to 11 in the Nutritional Health Checklist.

☐

12.a. Is the client at a high nutritional risk level? Must answer for NAPIS.

- ☐ Don't know
- ☐ No
- ☐ Yes

NUTRITIONAL RISK SCORE means:
0-2 GOOD: Recheck your score in 6 months
3-5 MODERATE RISK: Recheck your score in 3 months
6+ HIGH RISK : May need to talk to Doctor or Dietitian Enter any comments.....

_____

_____

_____

_____

13. Is the client interested in talking to a nutritionist about food intake and diet needs?

- ☐ A - Yes
- ☐ B - No
- ☐ C - Don't know

14. How many prescription medications do you take?

☐

15. About how tall are you in inches without your shoes?

☐

16. About how much do you weigh in pounds without your shoes?

☐

Calculated Body Mass Index

1F. Intake: SERVICE PROGRAM CHECKLIST

1.a. Is the client participating in any of the following services or programs?

- [ ] A - Home health aide (LNA)
- [ ] B - Homemaker program
- [ ] C - Hospice
- [ ] D - Nursing (RN)
- [ ] E - Social work services
- [ ] F1 - Physical therapy
- [ ] F2 - Occupational therapy
- [ ] F3 - Speech therapy
- [ ] G - Adult Day Health Services/Day Health Rehab
- [ ] H - Attendant Services Program
- [ ] I - Developmental Disability Services
- [ ] J - Choices for Care Medicaid Waiver (HB/ERC)
- [ ] K - Medicaid High-Tech services
- [ ] L - Traumatic Brain Injury waiver
- [ ] M - USDA Commodity Supplemental Food Program
- [ ] N - Congregate meals (Sr. Center)
- [ ] O - Emergency Food Shelf/Pantry
- [ ] P - Home Delivered Meals
- [ ] Q - Senior Farmer's Market Nutrition Program
- [ ] Q1 - Nutritional Counseling
- [ ] R - AAA Case Management
- [ ] S - Community Action Program (CAP)
- [ ] T - Community Mental Health services
- [ ] U - Dementia Respite grant/NFCSP Grant
- [ ] V - Eldercare Clinician
- [ ] W - Job counseling/vocational rehabilitation
- [ ] X - Office of Public Guardian
- [ ] Y - Senior companion
- [ ] Z - VCIL peer counseling
- [ ] AA - Association for the Blind and Visually Impaired
- [ ] BB - Legal Aid services
- [ ] CC - Assistive Community Care Services (ACCS)
- [ ] DD - Housing and Supportive Services (HASS)
- [ ] EE - Section 8 voucher, housing
- [ ] FF - Subsidized housing
- [ ] GG - ANFC
- [ ] HH - Essential Persons program
- [ ] II - Food Stamps
- [ ] JJ - Fuel Assistance
- [ ] KK - General Assistance program
- [ ] LL - Medicaid
- [ ] MM - QMB/SLMB
- [ ] NN - Telephone Lifeline
- [ ] OO - VHAP
- [ ] PP - VPharm (VHAP Pharmacy)
- [ ] RR - Emergency Response System
- [ ] SS - SSI
- [ ] TT - Veterans benefits
- [ ] UU - Weatherization
- [ ] VV - Assistive Devices

1.b. Does the client want to apply for any of the following services or programs?

- [ ] A - Home health aide (LNA)
- [ ] B - Homemaker program
- [ ] C - Hospice
- [ ] D - Nursing (RN)
- [ ] E - Social Work Services
- [ ] F1 - Physical therapy
- [ ] F2 - Occupational therapy
- [ ] F3 - Speech therapy
- [ ] G - Adult day services/Day Health Rehab
- [ ] H - Attendant Services Program
- [ ] I - Developmental Disability Services
- [ ] J - Choices for Care Medicaid Waiver (HB/ERC)
- [ ] K - Medicaid High-Tech Services
- [ ] L - Traumatic Brain Injury Waiver
- [ ] M - USDA Commodity Supplemental Food Program
- [ ] N - Congregate Meals (Sr. Center)
- [ ] O - Emergency Food Shelf/Pantry
- [ ] P - Home Delivered Meals
- [ ] Q - Senior Farmer's Market Nutrition Program
- [ ] Q1 - Nutrition Counseling
- [ ] R - AAA Case Management
- [ ] S - Community Action Program
- [ ] T - Community Mental Health Services
- [ ] U - Dementia Respite Grant Program/NFCSP Grant
- [ ] V - Eldercare Clinician
- [ ] W - Job counseling/vocational rehabilitation
- [ ] X - Office of Public Guardian
- [ ] Y - Senior companion
- [ ] Z - VCIL peer counseling
- [ ] AA - Association for the Blind and Visually Impaired
- [ ] BB - Legal Aid services
- [ ] CC - Assistive Community Care Services (ACCS)
- [ ] DD - Housing and Supportive Services (HASS)
- [ ] EE - Section 8 Voucher (Housing Choice)
- [ ] FF - Subsidized Housing
- [ ] GG - ANFC
- [ ] HH - Essential Persons program
- [ ] II - Food stamps
- [ ] JJ - Fuel Assistance
- [ ] KK - General Assistance Program
- [ ] LL - Medicaid
- [ ] MM - QMB/SLMB
- [ ] NN - Telephone Lifeline
- [ ] OO - VHAP
- [ ] PP - VPharm (VHAP Pharmacy)
- [ ] RR - Emergency Response System
- [ ] SS - SSI
- [ ] TT - Veterans Benefits
- [ ] UU - Weatherization
- [ ] VV - Assistive Devices

1G. intake: POVERTY LEVEL ASSESSMENT

1. Are you currently employed?

- [ ] A - Yes
- [ ] B - No

2. How many people reside in the client's household, including the client?

3. HOUSEHOLD INCOME: Estimate the total client's HOUSEHOLD gross income per month?

$

4. CLIENT INCOME: Specify the client's monthly income.

$

5. Is the client's income level below the national poverty level?

- [ ] A - Yes
- [ ] B - No
- [ ] C - Don't know

Current year used for Federal Poverty Level

Poverty Income test current yr Client only

Percent of poverty for client current year (if less than 1.0 client is in poverty)

Poverty Income Test current yr household

Percent of Poverty for household Current year

Food Stamp Eligibility Current Year

Food Stamp Monthly Gross Income Limit

Food Stamp Income Test current yr household

Food Stamp Eligible (1 = yes)

Fuel Assistance Current Year

Fuel Assistance Seasonal Percent Poverty Test

Fuel Assistance Crisis Percent Poverty Test

Fuel Assistance Shareheat Percent Poverty Test

Fuel Household Income - Fuel 60+ deduction

Fuel Percent of Poverty household current yr

1H1. Intake: FINANCIAL RESOURCES: Monthly Income

1.a.1. Client's monthly social security income.

$

1.a.2. Monthly social security income of the client's spouse

$

1.b.1. Client's monthly SSI income

$

1.b.2. Monthly SSI income of the client's spouse

$

1.c.1. Client's monthly retirement/pension income

$

1.c.2. Monthly retirement/pension income of the client's spouse.

$

1.d.1. Client's monthly interest income.

$

1.d.2. Monthly interest income of the client's spouse.

$

1.e.1. Client's monthly VA benefits income.

$

1.e.2. Monthly VA benefits income of the client's spouse.

$

1.f.1. Client's monthly wage/salary/earnings income

$

1.f.2. Monthly wage/salary/earnings income of the client's spouse.

$

1.g.1. Client's other monthly income.

$

1.g.2. Other monthly income of the client's spouse.

$

1H2. Intake: FINANCIAL RESOURCES: Monthly Expenses

2.a. Client's monthly rent.

$

2.a2. Client's monthly mortgage.

$

2.b. Client's monthly property tax.

$

2.c. Client's monthly heat bill.

$

2.d. Client's monthly utilities bill.

$

2.e. Client's monthly house insurance cost.

$

2.f. Client's monthly telephone bill.

$

2.g. Monthly amount of medical expense the client incurs.

$

2.h.1. Describe other expenses

_____

_____

_____

_____

2.h.2. Monthly amount of other expenses?

$

1H3. Intake: FINANCIAL RESOURCES: Savings/Assets

3.a.1. What is the name of the bank/institution where the client's checking account is located?

3.a.2. What is the client's checking account number?

3.a.3. What is the client's checking account balance?

$

3.b.1. What is the name of the bank/institution where the client's primary savings account is located?

3.b.2. What is the client's primary savings account number?

3.b.3. What is the client's primary savings account balance?

$

3.c.1. What is the source of Stocks/Bonds/CDs resources?

3.c.2. What is the amount from Stock/Bonds/CDs?

$

3.d.1. What is the name of the bank/institution where the client's burial account is located?

3.d.2. What is the client's burial account number?

3.d.3. What is the client's burial account balance?

$

3.e.1. What is the name of the client's primary life insurance company?

3.e.2. What is the client's primary life insurance policy number?

3.e.3. What is the face value of the client's primary life insurance policy?

$

3.e.4. What is the cash surrender value of the client's primary life insurance policy?

$

3.f.1. What is the name of the bank/institution where the client's other account #1 is located?

3.f.2. What is the client's other account number #1?

3.f.3. What is the client's other account #1 balance?

$

3.g.1. What is the name of the bank/institution where the client's other account #2 is located?

3.g.2. What is the client's other account number #2?

3.g.3. What is the client's other account #2 balance?

$

1H4. Intake: FINANCIAL RESOURCES: Health Insurance

4.a.1. Does the client have Medicare A health insurance?

- ☐ A - Yes
- ☐ B - No

4.a.2. What is the effective date of the client's Medicare A policy?

_____/_____/_____

4.a.3. What is the client's Medicare A policy number?

_____

4.a.4. What is the client's monthly Medicare A premium? (enter 0 if no premium)

$

4.b.1. Does the client have Medicare B health insurance?

- ☐ A - Yes
- ☐ B - No

4.b.2. What is the effective date of the client's Medicare B policy?

_____/_____/_____

4.b.3. What is the client's Medicare B policy number?

_____

4.b.4. What is the client's monthly Medicare B premium? (Enter 0 if no premium)

$

4.c.1. Does the client have Medicare C health insurance?

- ☐ A - Yes
- ☐ B - No

4.c.2. What is the name of the client's Medicare C plan?

_____

4.c.3. What is the effective date of the client's Medicare C policy?

_____/_____/_____

4.c.4. What is the client's Medicare C plan premium? (Enter 0 if no premium)

$

4.d.1. Does the client have Medicare D health insurance?

- ☐ A - Yes
- ☐ B - No

4.d.2. What is the name of the client's Medicare D plan?

_____

4.d.3. What is the effective date of the client's Medicare D plan?

_____/_____/_____

4.d.4. What is the client's Medicare D plan premium? (Enter 0 if no premium)

$

4.e.1. Does the client have Medigap health insurance?

- ☐ A - Yes
- ☐ B - No

4.e.2. What is the name of the client's Medigap health insurer?

_____

_____

_____

_____

4.e.3. What is the client's monthly Medigap premium? (Enter 0 if no premium)

$

4.f.1. Does the client have LTC health insurance?

- ☐ A - Yes
- ☐ B - No

4.f.2. What is the name of the client's LTC health insurer?

_____

_____

_____

_____

4.f.3. What is the client's monthly LTC premium? (Enter 0 if no premium)

$

4.g.1. Does the client have other health insurance?

- ☐ A - Yes
- ☐ B - No
- ☐ C - Don't know

4.g.2. Enter the name of the client's other health insurance carrier, if applicable.

_____

4.g.3. What is the client's other monthly premium? (Enter 0 if no premium)

$

4.h.1. Does the client have VPharm insurance?

- [ ] A - Yes
- [ ] B - No

4.h.2. What is the effective date of VPharm insurance?

_____/_____/_____

1H5. Intake: FINANCIAL RESOURCES: Comments

Comment on the client's current financial situation.

_____

_____

_____

_____

1H6. intake: FINANCIAL CALCULATIONS

Calculated Total Client Income

Calculated Client + Spouse Income

Calculated Monthly Insurance Expenses

Calculated Monthly non-insurance Expenses

Calculated Total Monthly Expenses

Calculated Total Income - Expenses

Calculated total assets balance

1I. Intake: "SELF NEGLECT", ABUSE, NEGLECT, AND EXPLOITATION SCREENING

1. Is the client refusing services and putting him/her self or others at risk of harm?

- [ ] A - Yes
- [ ] B - No
- [ ] C - Information unavailable

2. Does the client exhibit dangerous behaviors that could potentially put him/her self or others at risk of harm?

- [ ] A - Yes
- [ ] B - No
- [ ] C - Information unavailable

3. Can the Client make clear, informed decisions about his/her care needs (Regardless of the consequence of the decision)?

- [ ] A - Yes
- [ ] B - No
- [ ] C - Information unavailable

4. Is there evidence (Observed or reported) of suspected abuse, neglect or exploitation of the client by another person?

- [ ] A - Yes
- [ ] B - No
- [ ] C - Information unavailable

5. ASSESSOR ACTION: If answer to 1 or 2 is yes refer clients >60 to Area Agency on Aging or if <60 to Adult Protective Services. If 3 is yes, consider a negotiated risk contract. if 4 is yes mandated reportes must file a report of abuse...Enter comments..

_____

_____

_____

_____

2. Supportive Assistance

1. Who is the primary unpaid person who usually helps the client?

- [ ] A - Spouse or significant other
- [ ] B - Daughter or son
- [ ] C - Other family member
- [ ] D - Friend, neighbor or community member
- [ ] E - None

2. How often does the client receive help from his/her primary unpaid caregiver?

- [ ] A - Several times during day and night
- [ ] B - Several times during day
- [ ] C - Once daily
- [ ] F - Less often than weekly
- [ ] D - Three or more times per week
- [ ] E - One to two times per week
- [ ] G - Unknown

3. What type of help does the client's primary unpaid caregiver provide?

- [ ] A - ADL assistance
- [ ] B - IADL assistance
- [ ] C - Environmental support
- [ ] D - Psychosocial support
- [ ] E - Medical care
- [ ] F - Financial help
- [ ] G - Health care
- [ ] H - Unknown

4. What is the name of the client's primary unpaid caregiver?

_____

5. What is the relationship of the primary unpaid caregiver to the client?

6. What is the phone number of the client's primary unpaid caregiver?

7. What is the address of the client's primary unpaid caregiver?

8. In your role as a caregiver do you need assistance in any of the following areas?

- [ ] A - Job
- [ ] B - Finances
- [ ] C - Family responsibilities
- [ ] D - Physical health
- [ ] E - Emotional health
- [ ] F - Other

9. ASSESSOR ACTION:
If caregiver indicates factors in question #8 , discuss options for family support services and make appropriate referrals. Consider completing "Caregiver Self-Assessment Questionaire"
... Enter any Comments on Client's Support System.

3A. Living Environment: LIVING ENVIRONMENT HAZARDS

1. Do any structural barriers make it difficult for you to get around your home?

- [ ] A - Stairs inside home - must be used
- [ ] B - Stairs inside home - optionally used
- [ ] C - Stairs outside
- [ ] D - Narrow or obstructed doorways
- [ ] E - Other
- [ ] F - None

2. Do any of the following safety issues exist in your home?

- [ ] A - Inadequate floor, roof or windows
- [ ] B - Inadequate/insufficient lighting
- [ ] C - Unsafe gas/electric appliance
- [ ] D - Inadequate heating
- [ ] E - Inadequate cooling
- [ ] F - Lack of fire safety devices
- [ ] G - Flooring or carpeting problems
- [ ] H - Inadequate stair railings
- [ ] I - Improperly stored hazardous materials
- [ ] J - Lead-based paint
- [ ] K - Other
- [ ] L - None of the above

2.a. Other safety hazards found in the client's current place of residence.

3. Do any of the following sanitation issues exist in your home?

- [ ] A - No running water
- [ ] B - Contaminated water
- [ ] C - No toileting facilities
- [ ] D - Outdoor toileting facilities
- [ ] E - Inadequate sewage disposal
- [ ] F - Inadequate/improper food storage
- [ ] G - No food refrigeration
- [ ] H - No cooking facilities
- [ ] I - Insects/rodents present
- [ ] J - No trash pickup
- [ ] K - Cluttered/soiled living area
- [ ] L - Other
- [ ] M - None

3.a. Other sanitation hazards found in the client's current place of residence.

4A. Emotional/Behavior/Cognitive Status: EMOTIONAL WELL BEING

1. Have you been anxious a lot or bothered by nerves?

- [ ] A - Yes
- [ ] B - No
- [ ] C - No response

2. Have you felt down, depressed, hopeless or helpless?

- ☐ A - Yes
- ☐ B - No
- ☐ C - No response

3. Are you bothered by little interest or pleasure in doing things?

- ☐ A - Yes
- ☐ B - No
- ☐ C - No response

4. Have you felt satisfied with your life?

- ☐ A - Yes
- ☐ B - No
- ☐ C - No response

5. Have you had a change in sleeping patterns?

- ☐ A - Yes
- ☐ B - No
- ☐ C - No response

6. Have you had a change in appetite?

- ☐ A - Yes
- ☐ B - No
- ☐ C - No response

7. Have you thought about harming yourself?

- ☐ A - Yes
- ☐ B - No
- ☐ C - No response

8. Do you have a plan for harming yourself?

- ☐ A - Yes
- ☐ B - No

9. Do you have the means for carrying out the plan for harming yourself?

- ☐ A - Yes
- ☐ B - No

10. Do you intend to carry out the plan to harm yourself?

- ☐ A - Yes
- ☐ B - No

11. Have you harmed yourself before?

- ☐ A - Yes
- ☐ B - No

12. Are you currently being treated for a psychiatric problem?

- ☐ A - Yes
- ☐ B - No

13. Where are you receiving psychiatric services?

- ☐ A - At home
- ☐ B - In the community
- ☐ C - Both at home and in the community

14. If any question in this section was answered yes, what action did the assessor take?

15.READ. You have just expressed concerns about your emotional health. There are some resources and services that might be helpful; if you are interested I will initiate a referral or help you refer yourself .....Enter comments if any...

4B. Emotional/Behavior/Cognitive Status: COGNITIVE STATUS

1. What was the client's response when asked, 'What year is it?'

- ☐ A - Correct answer
- ☐ B - Incorrect answer
- ☐ C - No response

2. What was the client's response when asked, 'What month is it?'

- ☐ A - Correct answer
- ☐ B - Incorrect answer
- ☐ C - No response

3. What was the client's response when asked, 'What day of the week is it?'

- ☐ A - Correct answer
- ☐ B - Incorrect answer
- ☐ C - No response

4. Select the choice that most accurately describes the client's memory and use of information.

- ☐ A - No difficulty remembering
- ☐ B - Minimal difficulty remembering (cueing 1-3/day)
- ☐ C - Difficulty remembering (cueing 4+/day)
- ☐ D - Cannot remember

5. Select the choice that most accurately describes the client's global confusion.

- ☐ A - Appropriately responsive to environment
- ☐ B - Nocturnal confusion on awakening
- ☐ C - Periodic confusion in daytime
- ☐ D - Nearly always confused

6. Indicate the client's ability to speak and verbally express him or herself.

- ☐ A - Speaks normally (No observable impairment)
- ☐ B - Minimal or minor difficulty
- ☐ C - Moderate difficulty (can only carry simple conversations)
- ☐ D - Unable to express basic needs

7. What is the client's ability to make decisions regarding tasks of daily life?

- ☐ A - Independent - decisions consistent/reasonable
- ☐ B - Modified independence - some difficulty in new situations only
- ☐ C - Moderately impaired - decisions poor; cues/supervision
- ☐ D - Severely impaired - never/rarely makes decisions

ASSESSOR ACTION:
If EMOTIONAL HEALTH issues refer to Area Agency on Aging/Eldercare Clinician or Community mental health
If COGNITION issues refer to Doctor or Mental Health professional

4C. Emotional/Behavior/Cognitive Status: BEHAVIORAL STATUS

1.a. How often does the client get lost or wander?

- ☐ 0 - Never
- ☐ 1 - Less than daily
- ☐ 2 - Daily

1.b. In the last 7 days was the client's wandering behavior alterable?

- ☐ 0 - Behavior not present OR behavior easily altered
- ☐ 1 - Behavior was not easily altered

2.a. How often is the client verbally abusive?

- ☐ 0 - Never
- ☐ 1 - Less than daily
- ☐ 2 - Daily

2.b. In the last 7 days was the client's verbally abusive behavior alterable?

- ☐ 0 - Behavior not present OR behavior easily altered
- ☐ 1 - Behavior was not easily altered

3a. How often is the client physically abusive to others?

- ☐ 0 - Never
- ☐ 1 - Less than daily
- ☐ 2 - Daily

3.b. In the last 7 days was the client's physically abusive behavior alterable?

- ☐ 0 - Behavior not present OR behavior easily altered
- ☐ 1 - Behavior was not easily altered

4.a. How often does the client exhibit socially inappropriate/disruptive behavior? (e.g. disruptive sounds, noisiness, screaming, self-abusive acts, etc.)

- ☐ 0 - Never
- ☐ 1 - Less than daily
- ☐ 2 - Daily

4.b. In the last 7 days was the client's socially inappropriate or disruptive behavior symptoms alterable?

- ☐ 0 - Behavior not present OR behavior easily altered
- ☐ 1 - Behavior was not easily altered

5.a. How often did the client display symptoms of resisting care (resisted taking medications -injections, ADL assistance, or eating) in the last 7 days?

- ☐ 0 - Never
- ☐ 1 - Less than daily
- ☐ 2 - Daily

5.b. In the last 7 days was the client's resistance to care symptoms alterable?

- ☐ 0 - Behavior not present OR behavior easily altered
- ☐ 1 - Behavior was not easily altered

Comment on behaviors

5A. Health Assessment (for CFC must be completed by RN/LPN): DIAGNOSIS/CONDITIONS/TREATMENTS

1. Describe the client's primary diagnoses.

2. Indicate which of the following conditions/diagnoses the client currently has.

- [ ] A - ENDOCRINE-Diabetes
- [ ] B - ENDOCRINE-Hyperthyroidism
- [ ] C - ENDOCRINE-Hypothyroidism
- [ ] D - HEART-Arteriosclerotic heart disease (ASHD)
- [ ] E - HEART--Cardiac dysrhythmias
- [ ] F - HEART--Congestive heart failure
- [ ] G - HEART--Deep vein thrombosis
- [ ] H - HEART--Hypertension
- [ ] I - HEART--Hypotension
- [ ] J - HEART--Peripheral vascular disease
- [ ] K - HEART-Other cardiovascular disease
- [ ] L - MUSCULOSKELETAL-Arthritis/rheumatic disease/gout
- [ ] M - MUSCULOSKELETAL-Hip fracture
- [ ] N - MUSCULOSKELETAL-Missing limb (e.g., amputation)
- [ ] O - MUSCULOSKELETAL-Osteoporosis
- [ ] P - MUSCULOSKELETAL-Pathological bone fracture
- [ ] Q - NEUROLOGICAL-Alzheimer's disease
- [ ] R - NEUROLOGICAL-Aphasia
- [ ] S - NEUROLOGICAL-Cerebral palsy
- [ ] T - NEUROLOGICAL-Stroke
- [ ] U - NEUROLOGICAL - Non-Alzheimer's dementia
- [ ] V - NEUROLOGICAL-Hemiplegia/Hemiparesis
- [ ] W - NEUROLOGICAL-Multiple sclerosis
- [ ] X - NEUROLOGICAL-Paraplegia
- [ ] Y - NEUROLOGICAL-Parkinson's disease
- [ ] Z - NEUROLOGICAL-Quadriplegia
- [ ] AA - NEUROLOGICAL-Seizure disorder
- [ ] BB - NEUROLOGICAL-Transient ischemic attack (TIA)
- [ ] CC - NEUROLOGICAL-Traumatic brain injury
- [ ] DD - PSYCHIATRIC-Anxiety disorder
- [ ] EE - PSYCHIATRIC-Depression
- [ ] FF - PSYCHIATRIC- Bipolar disorder (Manic depression)
- [ ] GG - PSYCHIATRIC-Schizophrenia
- [ ] HH - PULMONARY-Asthma
- [ ] II - PULMONARY-Emphysema/COPD/
- [ ] JJ - SENSORY-Cataract
- [ ] KK - SENSORY-Diabetic retinopathy
- [ ] LL - SENSORY-Glaucoma
- [ ] MM - SENSORY-Macular degeneration
- [ ] MM1 - SENSORY- Hearing impairment
- [ ] NN - OTHER-Allergies
- [ ] OO - OTHER-Anemia
- [ ] PP - OTHER-Cancer
- [ ] QQ - OTHER-Renal failure
- [ ] RR - None of the Above
- [ ] SS - OTHER-Other significant illness

2.a. Enter any comments regarding the client's medical conditions/diagnoses.

_____

_____

_____

_____

3. Select all infections that apply to the client's condition based on the client's clinical record, consult staff, physician and accept client statements that seem to have clinical validity. Do not record infections that have been resolved.

- [ ] A - Antibiotic resistant infection (e.g.,Methicillin resistant staph)
- [ ] B - Clostridium difficile (c.diff.)
- [ ] C - Conjunctivitis
- [ ] D - HIV infection
- [ ] E - Pneumonia
- [ ] F - Respiratory infection
- [ ] G - Septicemia
- [ ] H - Sexually transmitted diseases
- [ ] I - Tuberculosis
- [ ] J - Urinary tract infection in last 30 days
- [ ] K - Viral hepatitis
- [ ] L - Wound infection
- [ ] M - None
- [ ] N - Other

4. Indicate what problem conditions the client has had in the past week.

- [ ] A - Dehydrated; output exceeds input
- [ ] B - Delusions
- [ ] C - Dizziness or lightheadedness
- [ ] D - Edema
- [ ] E - Fever
- [ ] F - Internal bleeding
- [ ] G - Recurrent lung aspirations in the last 90 days
- [ ] H - Shortness of breath
- [ ] I - Syncope (fainting)
- [ ] J - Unsteady gait
- [ ] K - Vomiting
- [ ] L - End Stage Disease (6 or fewer months to live)
- [ ] M - None of the above
- [ ] N - Other

5. Medical treatments that the client received during the last 14 days.

- ☐ A - TREATMENTS - Chemotherapy
- ☐ B - TREATMENTS - Dialysis
- ☐ C - TREATMENTS - IV medication
- ☐ D - TREATMENTS - Intake/output
- ☐ E - TREATMENTS - Monitoring acute medical condition
- ☐ F - TREATMENTS - Ostomy care
- ☐ G - TREATMENTS - Oxygen therapy
- ☐ H - TREATMENTS - Radiation
- ☐ I - TREATMENTS - Suctioning
- ☐ J - TREATMENTS - Tracheostomy care
- ☐ K - TREATMENTS - Transfusions
- ☐ L - TREATMENTS - Ventilator or respirator
- ☐ M - None of the Above
- ☐ N - Other

6. Indicate all therapies received by the client in the last seven (7) days.

- ☐ A - Speech therapy
- ☐ B - Occupational therapy
- ☐ C - Physical therapy
- ☐ D - Respiratory therapy
- ☐ E - None of the above

7. Does the client currently receive at least 45 minutes per day for at least 3 days per week of PT or a combination of PT, ST or OT?

- ☐ A - Yes
- ☐ B - No
- ☐ C - Information unavailable

8. Select all that apply for nutritional approaches.

- ☐ A - Parenteral/IV
- ☐ B - Feeding tube
- ☐ C - Mechanically altered diet
- ☐ D - Syringe (oral feeding)
- ☐ E - Therapeutic diet
- ☐ F - Dietary supplement between meals
- ☐ G - Plate guard, stabilized built-up utensil, etc
- ☐ H - On a planned weight change program
- ☐ I - Oral liquid diet
- ☐ J - None of the above

9. Select all that apply with regards to the client oral and dental status.

- ☐ A - Broken, loose, or carious teeth
- ☐ B - Daily cleaning of teeth/dentures or daily mouth care —by Client or staff
- ☐ C - Has dentures or removable bridge
- ☐ D - Inflamed gums (gingiva);swollen/bleeding gums;oral abscesses; ulcers or rashes
- ☐ E - Some/all natural teeth lost, does not have or use dentures or partial plate
- ☐ F - None of the above

10. High risk factors characterizing this client?

- ☐ A - Smoking
- ☐ B - Obesity
- ☐ C - Alcohol dependency
- ☐ D - Drug dependency
- ☐ E - Unknown
- ☐ G - None of the above

5B. Health Assessment (for CFC must be completed by RN/LPN): PAIN STATUS

1. Indicate the client's frequency of pain interfering with his or her activity or movement.

- ☐ A - No pain
- ☐ B - Less than daily
- ☐ C - Daily, but not constant
- ☐ D - Constantly

2. If the client experiences pain, does its intensity disrupt their usual activities? (e.g. sleep, eating, energy level)

- ☐ A - Yes
- ☐ B - No

5C. Health Assessment (for CFC must be completed by RN/LPN): SKIN STATUS

ULCER KEY. STAGE 1: Persistent area of skin redness(no break in skin) that doesn't disappear when pressure is relieved
STAGE2: Partial skin thickness loss, presents as an abrasion, blister, or shallow crater.

_____
_____
_____
_____

STAGE3: Full skin thickness loss, exposing subcutaneous tissues, presents as a deep crater.
STAGE 4: Full skin thickness loss, exposing subcutaneous tissues, exposing muscle or bone.

_____
_____
_____
_____

1.a. Specify the highest ulcer stage (1-4) for any pressure ulcers the client has (specify 0 if the client has no pressure ulcers).

1.b. Specify the highest ulcer stage (1-4) for any stasis ulcers the client has (specify 0 if the client has no pressure ulcers).

2. Indicate which of the following skin problems the client has that requires treatment.

- ☐ A - Abrasions or Bruises
- ☐ B - Burns (second or third degree)
- ☐ C - Open lesions other than ulcers, rashes or cuts
- ☐ D - Rashes
- ☐ E - Skin desensitized to pain or pressure
- ☐ F - Skin tears or cuts
- ☐ G - Surgical wound site
- ☐ H - None of the above

5D. Health Assessment (for CFC must be completed by RN/LPN): ELIMINATION STATUS

1. Has this client been treated for a urinary tract infection in the past 14 days?

- ☐ A - Yes
- ☐ B - No

2. What is the current state of the client's bladder continence (in the last 14 days) Client is continent if dribble volume is insufficient to soak through underpants with appliances used (pads or continence program)

- ☐ A - Yes Incontinent
- ☐ B - No incontinence nor catheter
- ☐ C - No incontinence has Urinary catheter

3. What is the frequency of bladder incontinence?

- ☐ A - Less than once weekly
- ☐ B - One to three times weekly
- ☐ C - Four to six times weekly
- ☐ D - One to three times daily
- ☐ E - Four or more times daily

4. When does bladder (urinary) incontinence occur?

- ☐ A - During the day only
- ☐ B - During the night only
- ☐ C - During the day and night

5. What is the current state of the client's bowel continence (in the last 14 days, or since the last assessment if less than 14 days)? Client is continent if control of bowel movement with appliance or bowel continence program.

- ☐ A - Incontinent
- ☐ B - No incontinence nor ostomy
- ☐ C - No incontinence has ostomy

6. What is the frequency of bowel incontinence?

- ☐ A - Less than once weekly
- ☐ B - One to three times weekly
- ☐ C - Four to six times weekly
- ☐ D - One to three times daily
- ☐ E - Four or more times daily

7. When does bowel incontinence occur?

- ☐ A - During the day only
- ☐ B - During the night only
- ☐ C - During the day and night

8. Has the client experienced recurring bouts of diarrhea in the last seven (7) days?

- ☐ A - Yes
- ☐ B - No

9. Has the client experienced recurring bouts of constipation in the last seven (7) days?

- ☐ A - Yes
- ☐ B - No

Comments regarding Urinary/Bowel Problems

5E. Health Assessment (for CFC must be completed by RN/LPN): COMMENTS and RN/LPN SIGNATURE

Comments regarding Medical Conditions

Enter the name of the Agency of RN/LPN.

What is the name of LPN/RN who completed Health Assessment section. SIGN BELOW

6A. Functional Assessment: ACTIVITIES of DAILY LIVING (ADLs)

KEY TO ADLS :
0=INDEPENDENT: No help at all OR help/oversight for 1-2 times 1=SUPERVISION: Oversight/cue 3+ times OR oversight/cue + physical help 1 or 2 times.

2=LIMITED ASSIST: Non-wt bearing physical help 3+times OR non-wt bearing help + extensive help 1-2 times 3=EXTENSIVE ASSIST: Wt-bearing help or full caregiver assistance 3+ times

4=TOTAL DEPENDENCE: Full caregiver assistance every time 8= Activity did not occur OR unknown.

1.A. DRESSING: During the past 7 days, how would you rate the client's ability to perform DRESSING? (putting on, fastening, taking off clothing, including prosthesis)

- ☐ 0 - INDEPENDENT: No help or oversight OR help provided 1 or 2 times
- ☐ 1 - SUPERVISION: Oversight/cueing 3+ times OR Oversight with physical help 1-2 time
- ☐ 2 - LIMITED ASSISTANCE: Non-wt bearing physical help 3+ times OR extensive help 1-2
- ☐ 3 - EXTENSIVE ASSISTANCE: Weight bearing help OR full caregiver assistance 3+ times
- ☐ 4 - TOTAL DEPENDENCE: Full assistance every time
- ☐ 8 - Activity did not occur OR unknown

1.B. Select the item for the most support provided during the last 7 days, for Dressing

- ☐ 0 - No setup or physical help
- ☐ 1 - Setup help only
- ☐ 2 - One person physical assist
- ☐ 3 - Two plus persons physical assist
- ☐ 8 - Activity did not occur in last 7 days OR unknown

dressing estimated minutes/day

1.C.1. DRESSING: How many MINUTES per DAY were needed for assistance in dressing? (Must enter zero if no time needed)

1.C.2. DRESSING: How many DAYS per WEEK does the client need PCA for ADL dressing? (Must enter zero if no time needed)

1.D. Comment on the client's ability in dressing.

2.A. BATHING: During the past 7 days, 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: No help at all
- ☐ 1 - SUPERVISION: Oversight/cueing only
- ☐ 2 - LIMITED ASSISTANCE: Physical help limited to transfer only
- ☐ 3 - EXTENSIVE ASSISTANCE: Physical help in part of bathing activity
- ☐ 4 - TOTAL DEPENDENCE: Full assistance every time
- ☐ 8 - Activity did not occur OR unknown

2.B. Select the item for the most support provided during the last 7 days, for Bathing.

- ☐ 0 - No setup or physical help
- ☐ 1 - Setup help only
- ☐ 2 - One person physical assist
- ☐ 3 - Two plus persons physical assist
- ☐ 8 - Activity did not occur in last 7 days OR unknown

bathing estimated minutes/day

2.C.1. BATHING: How many MINUTES per DAY were needed for assistance for bathing? (Must enter zero if no time needed)

2.C.2. BATHING: How many DAYS per WEEK does the client need PCA for ADL bathing? (Must enter zero if no time needed)

2.D. Comments regarding the client's bathing.

3.A. PERSONAL HYGIENE During the past 7 days, how would you rate the client's ability to perform PERSONAL HYGIENE? (combing hair, brushing teeth, shaving, washing/drying face, hands, perineum, EXCLUDE baths and showers)

- ☐ 0 - INDEPENDENT: No help or oversight OR help provided 1 or 2 times
- ☐ 1 - SUPERVISION: Oversight/cueing 3+ times OR Oversight with physical help 1-2 time
- ☐ 2 - LIMITED ASSISTANCE: Non-wt bearing physical help 3+ times OR extensive help 1-2
- ☐ 3 - EXTENSIVE ASSISTANCE: Weight bearing help OR full caregiver assistance 3+ times
- ☐ 4 - TOTAL DEPENDENCE: Full assistance every time
- ☐ 8 - Activity did not occur OR unknown

3.B. Select the item for the most support provided during the last 7 days, for Personal Hygiene

- ☐ 0 - No setup or physical help
- ☐ 1 - Setup help only
- ☐ 2 - One person physical assist
- ☐ 3 - Two plus persons physical assist
- ☐ 8 - Activity did not occur in last 7 days OR unknown

Personal Hygiene estimated minutes/day

3.C.1. PERSONAL HYGIENE: How many MINUTES per DAY were needed for assistance for personal hygiene?

3.C.2. PERSONAL HYGIENE: How many DAYS per WEEK does the client need PCA for ADL personal hygiene? (Must enter zero if no time needed)

3.D. Comment on the client's ability to perform personal hygiene

4.A. MOBILITY IN BED During the past 7 days, how would you rate the client's ability to perform MOBILITY IN BED? (moving to and from lying position, turning side to side, and positioning while in bed)

- ☐ 0 - INDEPENDENT: No help or oversight OR help provided 1 or 2 times
- ☐ 1 - SUPERVISION: Oversight/cueing 3+ times OR Oversight with physical help 1-2 time
- ☐ 2 - LIMITED ASSISTANCE: Non-wt bearing physical help 3+ times OR extensive help 1-2
- ☐ 3 - EXTENSIVE ASSISTANCE: Weight bearing help OR full caregiver assistance 3+ times
- ☐ 4 - TOTAL DEPENDENCE: Full assistance every time
- ☐ 8 - Activity did not occur OR unknown

4.B. Select the item for the most support provided during the last 7 days, for Bed Mobility.

- ☐ 0 - No setup or physical help
- ☐ 1 - Setup help only
- ☐ 2 - One person physical assist
- ☐ 3 - Two Plus persons physical assist
- ☐ 8 - Activity did not occur in last 7 days OR unknown

Mobility in Bed estimated min/day

NOTE: If full assistance is needed more than 6+x/day Bed Mobility estimated minutes/day =30

4.C.1. BED MOBILITY How many MINUTES per DAY were needed for assistance for bed mobility? (Must enter zero if no time needed)

4.C.2. BED MOBILITY How many DAYS per WEEK does the client need PCA for ADL bed mobility? (Must enter zero if no time needed)

4.D. Comments on clients bed mobility.

5.A. TOILET USE During the past 7 days, how would you rate the client's ability to perform TOILET USE? (using toilet, getting on/off toilet, cleansing self, managing incontinence)

- ☐ 0 - INDEPENDENT: No help or oversight OR help provided 1 or 2 times
- ☐ 1 - SUPERVISION: Oversight/cueing 3+ times OR Oversight with physical help 1-2 time
- ☐ 2 - LIMITED ASSISTANCE: Non-wt bearing physical help 3+ times OR extensive help 1-2
- ☐ 3 - EXTENSIVE ASSISTANCE: Weight bearing help OR full caregiver assistance 3+ times
- ☐ 4 - TOTAL DEPENDENCE: Full assistance every time
- ☐ 8 - Activity did not occur OR unknown

5.B. Select the item for the most support provided during the last 7 days, for Toilet Use

- ☐ 0 - No setup or physical help
- ☐ 1 - Setup help only
- ☐ 2 - One person physical assist
- ☐ 3 - Two plus persons physical assist
- ☐ 8 - Activity did not occur in last 7 days OR unknown

toileting estimated minutes/day

NOTE: If full assistance is needed more than 6+x/day Toileting estimated minutes/day =60

5.C.1. TOILET USE: How many MINUTES per DAY were needed for assistance for toilet use? (Must enter zero if no time needed)

5.C.2. TOILET USE: How many DAYS per WEEK were needed for assistance for toilet use? (Must enter zero if no time needed)

5.D. Comment on the client's ability to use the toilet.

6.A. ADAPTIVE DEVICES: During the past 7 days how do rate the client's ability to manage putting on and/or removing braces, splints, and other adaptive devices.

- ☐ 0 - INDEPENDENT: No help or oversight OR help provided 1 or 2 times
- ☐ 1 - SUPERVISION: Oversight/cueing 3+ times OR Oversight with physical help 1-2 time
- ☐ 2 - LIMITED ASSISTANCE: Non-wt bearing physical help 3+ times OR extensive help 1-2
- ☐ 3 - EXTENSIVE ASSISTANCE: Weight bearing help OR full caregiver assistance 3+ times
- ☐ 4 - TOTAL DEPENDENCE: Full assistance every time
- ☐ 8 - Activity did not occur OR unknown

6.B. Specify the most support provided for client's ability to care for his/her adaptive equipment.

- ☐ 0 - No setup or physical help
- ☐ 1 - Setup only
- ☐ 2 - One person physical assist
- ☐ 3 - Two plus persons physical assist
- ☐ 8 - Activity did not occur in last 7 days OR unknown

Adaptive devices estimated minutes/day

6.C.1. ADAPTIVE DEVICES: How many MINUTES per DAY were needed for assistance for adaptive devices? (Must enter zero if no time needed)

6.C.2. ADAPTIVE DEVICES: How many DAYS per WEEK does the client need PCA for ADL adaptive devices? (Must enter zero if no time needed)

6.D. Comment on adaptive devices.

7.A. TRANSFER: During the past 7 days, how would you rate the client's ability to perform TRANSFER? (moving to/from bed, chair, wheelchair, standing position, EXCLUDES to/from bath/toilet)

- ☐ 0 - INDEPENDENT: No help or oversight OR help provided 1 or 2 times
- ☐ 1 - SUPERVISION: Oversight/cueing 3+ times OR Oversight with physical help 1-2 time
- ☐ 2 - LIMITED ASSISTANCE: Non-wt bearing physical help 3+ times OR extensive help 1-2
- ☐ 3 - EXTENSIVE ASSISTANCE: Weight bearing help OR full caregiver assistance 3+ times
- ☐ 4 - TOTAL DEPENDENCE: Full assistance every time
- ☐ 8 - Activity did not occur OR unknown

7.B. Select the item for the most support provided during the last 7 days, for Transfer.

- ☐ 0 - No setup or physical help
- ☐ 1 - Setup help only
- ☐ 2 - One person physical assist
- ☐ 3 - Two plus persons physical assist
- ☐ 8 - Activity did not occur in last 7 days OR unknown

Transferring estimated minutes/day

NOTE: If full assistance is needed more than 6+x/day Transferring estimated minutes/day =45 (hoyer)

7.C.1. TRANSFERRING: How many MINUTES per DAY were needed for assistance for transferring? (Must enter zero if no time needed)

7.C.2. TRANSFERRING: How many DAYS per WEEK does the client need PCA for ADL transferring? (Must enter zero if no time needed)

7.D. Enter any comments regarding the client's ability to transfer.

8.A. MOBILITY: During the past 7 days, how would you rate the client's ability to perform MOBILITY IN HOME? (moving between locations in home. If in wheelchair, self-sufficiency once in wheelchair)

- ☐ 0 - INDEPENDENT: No help or oversight OR help provided 1 or 2 times
- ☐ 1 - SUPERVISION: Oversight/cueing 3+ times OR Oversight with physical help 1-2 time
- ☐ 2 - LIMITED ASSISTANCE: Non-wt bearing physical help 3+ times OR extensive help 1-2
- ☐ 3 - EXTENSIVE ASSISTANCE: Weight bearing help OR full caregiver assistance 3+ times
- ☐ 4 - TOTAL DEPENDENCE: Full assistance every time
- ☐ 8 - Activity did not occur OR unknown

8.B. Select the item for the most support provide for mobility in last 7 days

- ☐ 0 - No setup or physical help
- ☐ 1 - Setup help only
- ☐ 2 - One person physical assist
- ☐ 3 - Two + person physical assist
- ☐ 8 - Activity did not occur in last 7 days OR unknown

Mobility (walking) estimated min/day

NOTE: If full assistance is needed more than 6+x/day Mobility estimated minutes/day =45

8.C.1. MOBILITY: How many MINUTES per DAY were needed for assistance for mobility (ambulation/locomotion)? (Must enter zero if no time needed)

8.C.2. MOBILITY: How many DAYS per WEEK does the client need PCA for ADL mobility? (Must enter zero if no time needed)

8.D. Comment on the client's ability to get around inside the home.

9.A. EATING: During the past 7 days, how would you rate the client's ability to perform EATING? (ability to eat and drink regardless of skill. Includes intake of nourishment by other means (e.g. tube feeding, total parenteral nutrition)

- ☐ 0 - INDEPENDENT: No help or oversight OR help provided 1 or 2 times
- ☐ 1 - SUPERVISION: Oversight/cueing 3+ times OR Oversight with physical help 1-2 time
- ☐ 2 - LIMITED ASSISTANCE: Non-wt bearing physical help 3+ times OR extensive help 1-2
- ☐ 3 - EXTENSIVE ASSISTANCE: Weight bearing help OR full caregiver assistance 3+ times
- ☐ 4 - TOTAL DEPENDENCE: Full assistance every time
- ☐ 8 - Activity did not occur OR unknown

9.B. Select the item for the most support provided during the last 7 days, for Eating

- ☐ 0 - No setup or physical help
- ☐ 1 - Setup help only
- ☐ 2 - One person physical assist
- ☐ 3 - Two plus persons physical assist
- ☐ 8 - Activity did not occur in last 7 days OR unknown

eating estimated minutes/day

9.C.1. EATING: How many MINUTES per DAY were needed for assistance for eating? (Must enter zero if no time needed)

9.C.2. EATING: How many DAYS per WEEK does the client need PCA for ADL eating? (Must enter zero if no time needed)

9.D. Comment on the client's ability to eat.

What is the client's ADL count?

10. How many ADL impairments does the client have (Count or Total)? Must answer for NAPIS.

6B. Functional Assessment: INSTRUMENTAL ACTIVITIES of DAILY LIVING (IADLs)

1.A. PHONE: During the last 7 days, Rate the client's ability to use the PHONE. (Answering the phone, dialing numbers, and effectively using the phone to communicate)

- ☐ 0 - INDEPENDENT: No help provided (With/without assistive devices)
- ☐ 1 - DONE WITH HELP: Cueing, supervision, reminders, and/or physical help provided
- ☐ 2 - DONE BY OTHERS: Full caregiver assistance
- ☐ 8 - Activity did not occur OR unknown

1.B. Indicate the highest level of phone use support provided in the last seven (7) days.

- ☐ 0 - No setup or physical help
- ☐ 1 - Supervision/cueing
- ☐ 2 - Setup help only
- ☐ 3 - Physical assistance
- ☐ 8 - Activity did not occur or unknown

1.D. Comment on the client's ability to use the telephone.

_____

_____

_____

_____

2.A. MEAL PREPARATION: During the past 7 days, how would you rate the client's ability to perform MEAL PREPARATION? (planning and preparing light meals or reheating delivered meals)

- ☐ 0 - INDEPENDENT: No help provided (With/without assistive devices)
- ☐ 1 - DONE WITH HELP: Cueing, supervision, reminders, and/or physical help provided
- ☐ 2 - DONE BY OTHERS: Full caregiver assistance
- ☐ 8 - Activity did not occur OR unknown

2.B. Indicate the most support provided for meal prep in the last seven (7) days.

- ☐ 0 - No setup or physical help
- ☐ 1 - Supervision/cueing
- ☐ 2 - Setup help only
- ☐ 3 - Physical assistance
- ☐ 8 - Activity did not occur or unknown

Meal prep estimated minutes/day

2.C.1. MEAL PREP: How many MINUTES per DAY were needed for assistance for meal preparation? (Must enter zero if no time needed)

2.C.2. MEAL PREP: How many DAYS per WEEK does the client need PCA for IADL meal prep? (Must enter zero if no time needed)

2.D. Comment on the client's ability to prepare meals.

_____

_____

_____

_____

3.A. MEDICATIONS MANAGEMENT: During the past 7 days, how would you rate the client's ability to perform MEDICATIONS MANAGEMENT? (preparing/taking all prescribed and over the counter medications reliably and safely, including correct dosage at correct times)

- ☐ 0 - INDEPENDENT: No help provided (With/without assistive devices)
- ☐ 1 - DONE WITH HELP: Cueing, supervision, reminders, and/or physical help provided
- ☐ 2 - DONE BY OTHERS: Full caregiver assistance
- ☐ 8 - Activity did not occur OR unknown

3.B. Indicate the most support provided for medications management in the last seven (7) days.

- ☐ 0 - No setup or physical help
- ☐ 1 - Supervision/cueing
- ☐ 2 - Setup help only
- ☐ 3 - Physical assistance
- ☐ 8 - Activity did not occur or unknown

Meds mgt estimated minutes/day

3.C.1. MEDICATIONS MANAGEMENT: How many MINUTES per DAY were needed for assistance for medications management. (Must enter zero if no time needed)

3.C.2. MEDICATIONS MANAGEMENT: How many DAYS per WEEK does the client need for IADL medications management? (Must enter zero if no time needed)

3.D. Comment on the client's ability to take his/her medication.

_____

_____

_____

_____

4.A. MONEY MANAGEMENT: During the last 7 days how do you rate the client's ability to manage money. (payment of bills, managing checkbook/accounts, being aware of potential exploitation, budgets, plans for emergencies etc.)

- ☐ 0 - INDEPENDENT: No help provided (With/without assistive devices)
- ☐ 1 - DONE WITH HELP: Cueing, supervision, reminders, and/or physical help provided
- ☐ 2 - DONE BY OTHERS: Full caregiver assistance
- ☐ 8 - Activity did not occur OR unknown

4.B. Indicate the most support provided for money management in the last seven (7) days.

- [ ] 0 - No setup or physical help
- [ ] 1 - Supervision/cueing
- [ ] 2 - Setup help only
- [ ] 3 - Physical assistance
- [ ] 8 - Activity did not occur or unknown

4.D. Comment on the client's ability to manage money.

5.A. HOUSEHOLD MAINTENANCE: During the past 7 days rate the client's ability to perform HOUSEHOLD MAINTENANCE. (chores such as washing windows, shoveling snow, taking out garbage and scrubbing floors)

- [ ] 0 - INDEPENDENT: No help provided (With/without assistive devices)
- [ ] 1 - DONE WITH HELP: Cueing, supervision, reminders, and/or physical help provided
- [ ] 2 - DONE BY OTHERS: Full caregiver assistance
- [ ] 8 - Activity did not occur OR unknown

5.B. Indicate the highest level of household maintenance support provided in the last seven (7) days.

- [ ] 0 - No setup or physical help
- [ ] 1 - Supervision/cueing
- [ ] 2 - Setup help only
- [ ] 3 - Physical assistance
- [ ] 8 - Activity did not occur or unknown

5.D. Comment on the client's ability to perform household maintenance chores.

6.A. LIGHT HOUSEKEEPING: During the last 7 days how would you rate the client's ability to perform light housekeeping. (dusting. sweeping, vacuuming, dishes, light mop, and picking up)

- [ ] 0 - INDEPENDENT: No help provided (With/without assistive devices)
- [ ] 1 - DONE WITH HELP: Cueing, supervision, reminders, and/or physical help provided
- [ ] 2 - DONE BY OTHERS: Full caregiver assistance
- [ ] 8 - Activity did not occur OR unknown

6.B. Indicate the most support provided for housekeeping in the last seven (7) days.

- [ ] 0 - No setup or physical help
- [ ] 1 - Supervision/cueing
- [ ] 2 - Setup help only
- [ ] 3 - Physical assistance
- [ ] 8 - Activity did not occur or unknown

6.D. Comment on the client's ability to do ordinary housekeeping.

7.A. LAUNDRY During the last 7 days how do rate the client's ability to perform laundry. (carrying laundry to and from the washing machine, using washer and dryer, washing small items by hand)

- [ ] 0 - INDEPENDENT: No help provided (With/without assistive devices)
- [ ] 1 - DONE WITH HELP: Cueing, supervision, reminders, and/or physical help provided
- [ ] 2 - DONE BY OTHERS: Full caregiver assistance
- [ ] 8 - Activity did not occur OR unknown

7.B. Indicate the most support provided for laundry in the last seven (7) days.

- [ ] 0 - No setup or physical help
- [ ] 1 - Supervision/cueing
- [ ] 2 - Setup help only
- [ ] 3 - Physical assistance
- [ ] 8 - Activity did not occur or unknown

7.D. Comment on the client's ability to do laundry.

8.A. SHOPPING: During the past 7 days, how would you rate the client's ability to perform SHOPPING? (planning, selecting, and purchasing items in a store and carrying them home or arranging delivery if available)

- [ ] 0 - INDEPENDENT: No help provided (With/without assistive devices)
- [ ] 1 - DONE WITH HELP: Cueing, supervision, reminders, and/or physical help provided
- [ ] 2 - DONE BY OTHERS: Full caregiver assistance
- [ ] 8 - Activity did not occur OR unknown

8.B. Indicate the highest level of shopping support provided in the last seven (7) days.

- ☐ 0 - No setup or physical help
- ☐ 1 - Supervision/cueing
- ☐ 2 - Setup help only
- ☐ 3 - Physical assistance
- ☐ 8 - Activity did not occur or unknown

8.D. Comment on the client's ability to do shopping.

_____

_____

_____

_____

9.A. TRANSPORTATION: During the past 7 days, how would you rate the client's ability to perform TRANSPORTATION? (safely using car, taxi or public transportation)

- ☐ 0 - INDEPENDENT: No help provided (With/without assistive devices)
- ☐ 1 - DONE WITH HELP: Cueing, supervision, reminders, and/or physical help provided
- ☐ 2 - DONE BY OTHERS: Full caregiver assistance
- ☐ 8 - Activity did not occur OR unknown

9.B. Indicate the highest level of transportation support provided in the last seven (7) days.

- ☐ 0 - No setup or physical help
- ☐ 1 - Supervision/cueing
- ☐ 2 - Setup help only
- ☐ 3 - Physical assistance
- ☐ 8 - Activity did not occur or unknown

9.D. Comment on the client's ability to use transportation.

_____

_____

_____

_____

10.A. EQUIPMENT MANAGEMENT: During last 7 days rate client's ability to manage equipment (cleaning , adjusting or general care of adaptive/medical equipment such as wheelchairs, walkers, nebulizer, IV equipment etc.)

- ☐ 0 - INDEPENDENT: No help provided (With/without assistive devices)
- ☐ 1 - DONE WITH HELP: Cueing, supervision, reminders, and/or physical help provided
- ☐ 2 - DONE BY OTHERS: Full caregiver assistance
- ☐ 8 - Activity did not occur OR unknown

10.B. Indicate the highest level of care of equipment support provided in the last seven (7) days.

- ☐ 0 - No setup or physical help
- ☐ 1 - Supervision/cueing
- ☐ 2 - Setup help only
- ☐ 3 - Physical assistance
- ☐ 8 - Activity did not occur or unknown

11. Is the program application for the client for ASP or Other programs? If it is not ASP then the following IADL questions will be skipped.

- ☐ A - Attendant Services program
- ☐ B - Other

What is the client's IADL count?

12. How many IADL impairments does the client have (Count or Total)? Must answer for NAPIS.

☐

6.C.1. ASP Only - Extra IADL Questions

11.A. INFANT/CHILD CARE (ASP only): During last 7 days rate client's ability to perform infant/child care. (bathing, dressing, feeding of own children to the extent that dependent child cannot self perform.

- ☐ 0 - - INDEPENDENT: No help provided (With/without assistive devices)
- ☐ 1 - DONE WITH HELP: Cueing, supervision, reminders, and/or physical help provided
- ☐ 2 - DONE BY OTHERS: Full caregiver assistance
- ☐ 8 - Activity does not occur

11.B. Indicate the highest level of child care support provided in the last seven (7) days.

- ☐ 0 - No setup or physical help
- ☐ 1 - Supervision/cueing
- ☐ 2 - Setup help only
- ☐ 3 - Physical assistance
- ☐ 8 - Activity did not occur or unknown

12.A. SUPPORT ANIMAL (ASP only): During last 7 days rate client's ability to care for support animal. (feeding, grooming, walking seeing-eye dog or hearing-ear dog or other support animal)

- ☐ 0 - - INDEPENDENT: No help provided (With/without assistive devices)
- ☐ 1 - DONE WITH HELP: Cueing, supervision, reminders, and/or physical help provided
- ☐ 2 - DONE BY OTHERS: Full caregiver assistance
- ☐ 8 - Activity does not occur

12.B. Indicate the highest level of support of animals support provided in the last seven (7) days.

- ☐ 0 - No setup or physical help
- ☐ 1 - Supervision/cueing
- ☐ 2 - Setup help only
- ☐ 3 - Physical assistance
- ☐ 8 - Activity did not occur or unknown

13.A. MOBILITY GUIDE (ASP only): For individuals who are blind or visually impaired, during last 7 days rate client's level of mobility. (get from place to place in and around home, shopping, and in medical or educational facilities)

- ☐ 0 - - INDEPENDENT: No help provided (With/without assistive devices)
- ☐ 1 - DONE WITH HELP: Cueing, supervision, reminders, and/or physical help provided
- ☐ 2 - DONE BY OTHERS: Full caregiver assistance
- ☐ 8 - Activity did not occur or unknown

13.B. Indicate the highest level of mobility guide support provided in the last seven (7) days.

- ☐ 0 - No setup or physical help
- ☐ 1 - Setup help only
- ☐ 2 - Supervision/cueing
- ☐ 3 - Physical assistance
- ☐ 8 - Activity did not occur or unknown

6.C.2. ASP only worksheet questions

1.C.1. PHONE: (only enter for ASP) How many MINUTES per DAY were needed for assistance for phone use. (must enter zero if no time is needed)

1.C.2. PHONE: (enter for ASP only) How many DAYS per WEEK does the client need PCA for IADL phone use? (enter zero if no time needed)

4.C.1. MONEY MANAGEMENT: (only enter for ASP) How many MINUTES per WEEK were needed for assistance for MONEY MANAGEMENT. (must enter zero if no time is needed)

5.C.1. HOUSEHOLD MAINTENANCE: (only enter for ASP) How many MINUTES per WEEK were needed for assistance for HOUSEHOLD MAINTENANCE. (must enter zero if no time is needed)

6.C.1. LIGHT HOUSEKEEPING: (only enter for ASP) How many MINUTES per WEEK were needed for assistance for LIGHT HOUSEKEEPING. (must enter zero if no time is needed)

8.C.1. SHOPPING: (only enter for ASP) How many MINUTES per WEEK were needed for assistance for SHOPPING. (must enter zero if no time is needed)

9.C.1. TRANSPORTATION: (ENTER FOR asp ONLY) How many MINUTES per WEEK were needed for assistance for transportation? (Must enter zero if no time needed)

10.C.1. EQUIPMENT MANAGEMENT: (only enter for ASP) How many MINUTES per WEEK were needed for assistance for EQUIPMENT MANAGEMENT. (must enter zero if no time is needed)

11.C. CHILD CARE: How many MINUTES per WEEK were needed for assistance for child care?

12.C.1. SUPPORT ANIMAL CARE: How many MINUTES per WEEK were needed for assistance for care for support animal?

13.C.1. MOBILITY GUIDE: How many MINUTES per WEEK were needed for assistance for mobility guide?

14. ADAPTIVE EQUIPMENT : (only enter for ASP) How many MINUTES per WEEK were needed for assistance for ADAPTIVE EQUIPMENT (must enter zero if no time is needed)

Enter any comments regarding the client's ability to perform Mobility Outdoors.

6D. Functional Assessment: ADL/IADL Unmet Needs

Enter any additional comments regarding IADLs.

ADL/IADL Comments- Identify unmet needs if any.
Variance request must include
1. Description of client's specific unmet need
2. Why unmet need cannot be met with other services
3. Actual/immediate risk client's to health/welfare posed by unmet need

7A. Estimated/requested Incontinence needs:

Bowel needs estimated min/day

BOWEL: How many MINUTES per DAY were needed for assistance for bowel incontinence?

BOWEL: How many DAYS per WEEK were needed for assistance for bowel incontinence?

Urinary needs estimated min/day

BLADDER: How many MINUTES per DAY were needed for assistance for bladder incontinence?

BLADDER: How many DAYS per WEEK were needed for assistance for bladder incontinence?

2. Calculated needs for HCBS Personal Care Worksheet

2.A. Calculated ADL/Meal Prep + Meds Management needs

Dressing minutes/week

bathing minutes/week calculated

Hygiene min/week calculated

Bed mobility min/week calculated

Toilet min/week calculated

Adap device min/week calculated

Transfer min/week calculated

Mobility min/week calculated

Eating min/week calculated

Total ADL min/week calculated

Total ADL hours/week calculated

Meal prep min/week calculated

Med mgt min/week calculated

2.B. Calculated Incontinence needs

urinary needs min/week calculated

Bowel needs min/week calculated

2.C. LTC Waiver (Choices for Care) Calculated Needs

Total Incontinence hrs/week calculated

Total ADL + meal prep +meds mgt min/wk

hours per day for IADL tasks?

days per week assistance needed with IADL tasks?

Enter min/week for all IADLs except Meal Prep and Medication Management. Cannot exceed 270 (max IADL min/wk allowed).

Enter Comments on min/week for all IADLs except Meal Prep and Medication Management. Cannot exceed 270 (max IADL min/wk allowed).

Total IADL assistance min/week

Max IADL min/wk allowed

Total IADL max min/wk

Total LTC Waiver min/wk

Total LTC Waiver hrs/wk

Total LTC Waiver hrs/2 wks

Total LTC Waiver hrs/mo

3. Potential Issues Checklist

3.A. Health Issues checklist (1 indicates area for follow-up)

- **Issue Emergency preparedness**
- **Issue Client lives alone**
- **Issue Client has Fallen recently**
- **Issue Nutritional Risk (>=6)**
- **Issue Prescription meds (>=5)**
- **Issue depressed,anxious,hopeless**
- **Issue Incontinent bowels or urinary**
- **Issue Pain disrupts usual activities**
- **Issue End Stage Disease -6 or fewer months to live**

3.B. Other Issues checklist (1 indicates area for follow-up)

- **Issue No Power of Attorney**
- **Issue No Advance Directives**
- **Issue Lost/gained 10 pounds**
- **Issue No money to buy food**
- **Issue Client in poverty**
- **Issue No Medigap insurance**
- **Issue Client refuses services**
- **Issue Client has dangerous behavior**
- **Issue Client cannot make clear decisions**
- **Issue Evidence of abuse**
- **Issue Thought about harming self**
- **Issue Plan for harming self**
- **Issue Means to carry out plan to harm self**
- **Issue Getting lost/wandering**
- **Issue Wandering behavior not alterable**
- **Issue Verbally abusive behavior not alterable**
- **Issue Physical abuse behavior not alterable**
- **Issue Sanitation hazards**
- **Issue Structural barriers in home**
- **Issue Living space hazards**
- **Issue Wants other program-service**
- **Issue Needs equipment repaired**

3.C. Acuity Scores

- **Acuity ADLs (max 32)**
- **Acuity IADLs (max 18)**
- **Acuity cognition (max 15)**
- **Acuity bladder continence**
- **Acuity bowel continence**
- **Acuity total score (max 73)**
- **ACUITY percent**

Title : _____ Date

Title : _____ Date

Wyoming Department of Health

Commit to your health. visit www.health.wyo.gov

Caregiver Evaluation

Caregiver's Name:		
Initial Evaluation Date:		
Re-evaluation Date:		
Items:	**No**	**Yes**
Time Dependency Items: Do you Feel ~	**0**	**1**
He/she needs my help to perform many daily task		
He/she is dependent on you		
You have to watch him/her constantly		
You have to help him/her with many basic functions		
You don't have a minute's break from his/her chores		
Development Items: Do you Feel ~		
That you want to escape from this situation		
Your social life has suffered		
Emotionally drained due to caring for him/her		
Things would be different at this point in your life		
Completely overwhelmed/lonely		
A loss of privacy and/or personal time		
You don't have enough knowledge or experience to give care as well as you would like		
Physical Health Items: Do you Feel ~		
Tired – not getting enough sleep		
Your health has suffered (headaches, stomach problems, etc.)		
You have trouble keeping your mind on what you were doing		
You have difficulty making decisions		
You have had crying spells or deep sadness		
You have frequent pain (back pain, etc.)		
Have you lost or gained 10 pounds in the past 6 months		
Social Relationships Items: Do you Feel ~		
You don't get along with other family members as well as you used to		
My caregiving efforts aren't appreciated by others in my family		
You've had problems with your marriage (or other significant relationship)		
You don't get along as well as you used to with others		
Emotional Health Items: Do you Feel ~		
Embarrassed over his/her behavior		
Uncomfortable when you have friends over (social relationships)		
Resentment towards him/her		
Upset that the person I'm caring for has changed so much from his/her former self		
Family members **aren't** helping you with Caregiving responsibilities?		
Strained between work and family responsibilities		
20-30 Plus Caregiver needs relief / **10-19** Caregiver needs assistance / **0-9** Caregiver needs to be contacted annually.		
Total Score		

Access Care Coordinator's Signature Date

Caregiver's Signature Date

I give permission for sharing of information directly related to my health, social, environmental and economic status with those agencies potentially providing services as necessary for up to one year to assist me in receiving the most appropriate care in the most appropriate environment. I further understand that data gathered as result of these services provided for me may be used in reporting and research. These results will be released to the Wyoming Department of Health, Aging Division for statistical study and service verification and my confidentiality will be maintained.

October 2012