VT DAIL Full ILA15

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.

9.e. Are you living in the setting of your choice?

- [ ] No
- [ ] Yes

Describe the client's goals and objectives in the narrative section of this assessment.

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. 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

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?

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.....

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

- ☐ A - Yes
- ☐ B - No
- ☐ C - Don't know

13. How many prescription medications do you take?

14. About how tall are you in inches without your shoes?

15. 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

1.a. Is the client participating in any of the following services or programs?

- [ ] 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

1.b. Does the client want to apply for any of the following services or programs?

- ☐ 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

5F. LTCCC Reviewer Information

LTCCC whodid clinical assessment or reviewed the assessment

Date clinical assessment was done or reviewed by DAIL LTCCC:

_____/_____/_____

Utilization Review Comments

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? (M ust 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? (Mu st 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 (h oyer)

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?

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 (cle aning , 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?

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 to client's 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

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

IADLs over Max (1 =yes, 0=no)

3. Service Plan

3.A. Service Plan Request Information

1. What type of care plan is this? (Select One)

- ☐ A - Initial
- ☐ B - Reassessment
- ☐ C - Change

1a. Reason for care plan change

2. Primary diagnoses for long term care needs in ICD code format. Multiple codes may be added but primary should be first code.

List each medical diagnosis or problem for which the patient is receiving care and ICD code category (three digits required; five digits optional - no surgical or V-codes) and rate them using the following severity index. (Choose one value that represents the most severe rating appropriate for each diagnosis.)

0 Asymptomatic, no treatment needed at this time
1 Symptoms well controlled with current therapy
2 Symptoms controlled with difficulty, affecting daily functioning, needs ongoing monitoring
3 Symptoms poorly controlled; needs frequent adjustment in treatment and dose monitoring
4 Symptoms poorly controlled; history of rehospitializations

Choose one value that represents the disease code for this diagnosis .

0 Not Present - No Answer
1 Primary diagnosis/diagnosis for current stay
2 Diagnosis present, receiving active treatement
3 Diagnosis present, monitored but no active treatement

Diagnosis	Diagnosis Code	Severity Rating	Disease Code

3. Requested Plan of Care Start Date

_____/_____/_____

3.A.1. CASE MANAGEMENT

What is the case management provider type?

☐ A - AAA
☐ B - Home health

2. case management provider

Max case mgt hrs/yr

3.A.2. PERSONAL CARE

Total LTC waiver Personal Care hrs/2 wks

Total LTC Waiver hrs/2 wks + IADL variance request

1. Total Personal Care Hrs/ 2 wks (Enter the highest of the 2 numbers above rounded to the nearest .25)

2. HOME HEALTH personal care provider#1

2a. HOME HEALTH Personal Care provider #1 hrs 2/wks

3. HOME HEALTH personal care provider #2

3a. HOME HEALTH Personal Care provider #2 hrs 2/wks

4. CONSUMER/SURROGATE Personal Care provider (Fiscal ISO)

4a. CONSUMER directed Personal care hrs/2 wks

4b. SURROGATE directed Personal care hrs/ 2 wks

3.A.3. ADULT DAY

1. ADULT DAY Provider

2. ADULT DAY hrs/ 2 weeks

3.A.4. RESPITE CARE

1. HOME HEALTH Respite Provider #1

1a. HOME HEALTH Respite provider #1 hrs/yr

2. HOME HEALTH Respite Provider #2

2a. HOME HEALTH Respite provider #2 hrs/yr

3. CONSUMER/SURROGATE Respite provider (Fiscal ISO)

3a. CONSUMER directed Respite hrs/yr

3b. SURROGATE directed Respite hrs/yr

4. ERC (enhanced residential care) Respite provider?

4a. ERC Respite days/yr

5. Respite Adult Day provider name

5a. Respite Adult Day hrs/yr

3.A.5. COMPANION

1. HOME HEALTH Companion Provider #1

1a. HOME HEALTH Companion provider #1 hrs/yr

2. HOME HEALTH Companion Provider #2:

2a. HOME HEALTH Companion provider #2 hrs/yr

3. SENIOR COMPANION Provider #3:

3a. SENIOR COMPANION hrs/yr

4. CONSUMER/SURROGATE directed companion Provider (Fiscal ISO)

4a. CONSUMER directed Companion hrs/yr

4b. SURROGATE directed Companion hrs/yr

3.A.5a. RESPITE/COMPANION Max and Sum Requested

Max Respite/Companion hrs allowed per calendar yr

HB Companion Sum Requested

HB Respite Sum Requested

HB Respite/Companion Balance

3.A.6. PERSONAL EMERGENCY RESPONSE SYSTEM

RATE PERS installation

1. PERS Installation/first month cost

$

RATE PERS monthly cost

2. PERS ongoing cost/month

$

3. PERS provider?

3.A.7. ASSISTIVE DEVICES

Max assistive devices $/yr

3.A.8. ISO EMPLOYER SUPPORT SERVICES

ARIS ISO cost/mo

1. ISO Employer Support Services (ARIS)

$

If the individual spouse is an approved paid caregiver through CFC, they may only be paid to provide assistance with Activities of Daily Living (ADL). They MAY NOT be paid for IADLS's including meal prep, medication management or companion respite time.

3.B.1. Service Plan Request Hrs summary

Calc case mgt hrs/mo AAA

Calc case mgt hrs/mo HHA

Calc Personal Care Hrs/2 wks HHA 1

Calc Personal Care Hrs/2 wks HHA 2

calc Personal Care hrs/2 wks consumer

Calc Personal Care hrs/2 wks surrogate

Calc Adult Day hrs/2 wks

Calc Respite adult day hrs/yr

Calc Respite ERC days/yr

Calc Respite hrs/yr HHA 1

Calc Respite hrs/yr HHA 2

Calc Respite hrs/yr consumer

calc Respite hr/mo consumer

Calc Respite hrs/yr surrogate

calc Respite hrs/mo surrogate

Calc companion hrs/yr HHA1

calc Companion hrs/yr HHA 2

calc Companion hrs/mo HHA 1

Calc Companion hrs/mo HHA 2

Calc Companion senior companion hrs/yr

calc Companion senior companion hrs/mo

Calc Companion hrs/yr consumer

calc Companion hrs/mo consumer

Calc Companion hrs/yr surrogate

Calc Companion hrs/mo surrogate

Calc PERS monthly cost

Calc PERS install cost

Calc ISO cost/mo

Calc Respite ERC Total hrs/yr

Calc assistive device cost

Calc Total Respite hrs/yr

Calc Total Respite over max of 720 hrs/yr (1)

3.B.2. Service Plan Request $

POC case mgt AAA $/mo

POC case mgt HHA $/mo

POC Personal Care HHA 1 $/2 wks

POC Personal Care HHA 2 $/2 wks

POC Personal Care consumer $/2 wks

POC Personal Care surrogate $/2wks

POC Adult Day $/2 wks

POC RESPITE CONSUMER $/YR

POC RESPITE SURROGATE $/YR

POC RESPITE ADULT DAY $/YR

POC Respite HHA 1 $/yr

POC Respite HHA 2 $/yr

POC Companion HHA 1 $/yr

POC Companion HHA 2 $/yr

POC COMPANION SURROGATE $/YR

POC COMPANION CONSUMER $/YR

POC PERS Installation $/mo

POC PERS ongoing $/mo

POC assistive device at max $/yr

POC ISO Employer Support $/mo

The Case Manager certifies that the service plan was developed with the participant /applicant or their legal representative and all parties fully understand the terms of the proposed plan and consent to the terms of the plan.

☐ A - Yes

3.C. Service Plan Rates

Case Management rate $/hr

Rate PERSONAL CARE Consumer-surrogate $/hr

Rate PERSONAL CARE surrogate $/hr

Rate PERSONAL CARE HHA $/hr

Rate ADULT DAY $/hr

Rate RESPITE HHA $/hr

Rate RESPITE Consumer $/hr

Rate RESPITE Surrogate $/hr

Rate RESPITE Adult Day $/hr

Rate RESPITE Res Care Home $/day

Rate COMPANION HHA $/hr

Rate COMPANION Senior Companion $/hr

Rate COMPANION consumer $/hr

Rate Companion surrogate $/hr

HB Respite rate/hr HHA

HB Respite rate/hr consumer surrogate

HB Personal care $/hr rate consumer/surrogate

HB Personal care $/hr rate HHA

4. Potential Issues Checklist

4.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

4.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

4.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