VT Intake ILA 11

0. Cover Sheet

0.A. INDIVIDUAL IDENTIFICATION

0. ILA is being completed for which 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. Client's residential street address or Post Office box.

_____

9.b. Client's residential city or town.

_____

9.c. Client's state of residence.

_____

9.d. Enter the client's residential zip code.

_____

0.B. ASSESSOR INFORMATION

1. Agency the assessor works for?

_____

2. ILA completed by? (name of assessor)

_____

0.C. EMERGENCY CONTACT INFORMATION

1.a. Primary Emergency contact name?

_____

1a.1. Primary Emergency contact relationship

_____

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

_____

1.b.2. 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 client'sPrimary Emergency Contact?

1.f. ZIP code for the Primary emergency contact?

1.x1. Name of Emergency Contact #1

1.x2. Phone number of Emergency Contact #1?

1.x3. 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/ P.O box of the client's Emergency Contact #2?

2.d. City/town of the client's Emergency Contact #2?

2.e. State of the 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

0.D. DIRECTIONS TO CLIENT'S HOME

Directions to client's home.

1. Intake

1.A. 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. Specify the 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 - Chinese
- ☐ V - Vietnamese
- ☐ O - Other

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

_____

1.B. 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 the client's Advanced Directives?

_____

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

_____

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

_____

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

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

1.C.. DEMOGRAPHICS

1. What is your marital status?

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

2a. What is your 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 - Unavailable
- [ ] G - Other

2aG 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
- [ ] G - Other
- [ ] H - Native Hawaiian/Other Pacific Islander

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 - Unavailable
- [ ] I - Other

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

- [ ] A - Lives Alone
- [ ] B - Lives with others
- [ ] C - Don't know

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

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

1.D1. 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 currently have any of the following conditions/diagnoses?

- [ ] A - Heart problems
- [ ] B - Arthritis/rheumatic disease/gout
- [ ] C - Diabetes
- [ ] D - Cancer
- [ ] E - Stroke
- [ ] F - Neurological condition
- [ ] G - Breathing disorders
- [ ] H - Digestive problems
- [ ] I - Muscle or bone problems
- [ ] J - Chronic pain
- [ ] K - Chronic weakness/fatigue
- [ ] L - Ankle/leg swelling
- [ ] M - Urinary problems
- [ ] N - Speech impairment
- [ ] O - Hearing impairment
- [ ] P - Vision problems
- [ ] Q - Non-Alzheimer's dementia
- [ ] R - Depression
- [ ] S - Any psychiatric diagnosis
- [ ] T - Anxiety disorder
- [ ] U - Other significant illness
- [ ] V - Alzheimer's disease

9. Enter any comments regarding the client's medical conditions/diagnoses.

10. 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

1.D.2.A. HEALTH RELATED QUESTIONS: Functional Needs: ADL Checklist

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. 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/oversight provided 1or 2 times.
- [ ] 1 - SUPERVISION: Oversight/cue 3+ times OR Oversight/cue + physical help 1-2 times
- [ ] 2 - LIMITED ASSIST: Non-wt bearing help 3+ times OR this + extensive help 1-2 time
- [ ] 3 - EXTENSIVE ASSIST: Wt- bearing help or full caregiver assistance 3+ times
- [ ] 4 - TOTAL DEPENDENCE: Full assistance every time
- [ ] 8 - Activity did not occur OR unknown.

2. 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/cue 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.

3. 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 at all OR help only 1-2 times
- ☐ 1 - SUPERVISION: Oversight/cue 3+ times OR plus physical help 1-2 times
- ☐ 2 - LIMITED ASSISTANCE: Non-wt bearing help 3+ times OR PLUS extensive help 1-2 time
- ☐ 3 - EXTENSIVE ASSISTANCE: Wt-bearing help or full assistance 3+ times
- ☐ 4 - TOTAL DEPENDENCE: Full assistance every time
- ☐ 8 - Activity did not occur OR unknown.

4. 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 at all OR help only 1-2 times
- ☐ 1 - SUPERVISION: Oversight/cue 3+ times OR plus physical help 1-2 times
- ☐ 2 - LIMITED ASSISTANCE: Non-wt bearing help 3+ times OR PLUS extensive help 1-2 time
- ☐ 3 - EXTENSIVE ASSISTANCE: Wt-bearing help or full assistance 3+ times
- ☐ 4 - TOTAL DEPENDENCE: Full assistance every time
- ☐ 8 - Activity did not occur OR unknown.

5. 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 at all OR help only 1-2 times
- ☐ 1 - SUPERVISION: Oversight/cue 3+ times OR plus physical help 1-2 times
- ☐ 2 - LIMITED ASSISTANCE: Non-wt bearing help 3+ times OR PLUS extensive help 1-2 time
- ☐ 3 - EXTENSIVE ASSISTANCE: Wt-bearing help or full assistance 3+ times
- ☐ 4 - TOTAL DEPENDENCE: Full assistance every time
- ☐ 8 - Activity did not occur OR unknown.

6. ADAPTIVE DEVICES: During the past 7 days how would you rate the client's ability to manage putting on and/or removing braces, splints, and other adaptive devices.

- ☐ 0 - INDEPENDENT: No help at all OR help only 1-2 times
- ☐ 1 - SUPERVISION: Oversight/cue 3+ times OR plus physical help 1-2 times
- ☐ 2 - LIMITED ASSISTANCE: Non-wt bearing help 3+ times OR PLUS extensive help 1-2 time
- ☐ 3 - EXTENSIVE ASSISTANCE: Wt-bearing help or full assistance 3+ times
- ☐ 4 - TOTAL DEPENDENCE: Full assistance every time
- ☐ 8 - Activity did not occur OR unknown.

7. 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 at all OR help only 1-2 times
- ☐ 1 - SUPERVISION: Oversight/cue 3+ times OR plus physical help 1-2 times
- ☐ 2 - LIMITED ASSISTANCE: Non-wt bearing help 3+ times OR PLUS extensive help 1-2 time
- ☐ 3 - EXTENSIVE ASSISTANCE: Wt-bearing help or full assistance 3+ times
- ☐ 4 - TOTAL DEPENDENCE: Full assistance every time
- ☐ 8 - Activity did not occur OR unknown.

8. 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 at all OR help only 1-2 times
- ☐ 1 - SUPERVISION: Oversight/cue 3+ times OR plus physical help 1-2 times
- ☐ 2 - LIMITED ASSISTANCE: Non-wt bearing help 3+ times OR PLUS extensive help 1-2 time
- ☐ 3 - EXTENSIVE ASSISTANCE: Wt-bearing help or full assistance 3+ times
- ☐ 4 - TOTAL DEPENDENCE: Full assistance every time
- ☐ 8 - Activity did not occur OR unknown.

9. 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 at all OR help only 1-2 times
- ☐ 1 - SUPERVISION: Oversight/cue 3+ times OR plus physical help 1-2 times
- ☐ 2 - LIMITED ASSISTANCE: Non-wt bearing help 3+ times OR PLUS extensive help 1-2 time
- ☐ 3 - EXTENSIVE ASSISTANCE: Wt-bearing help or full assistance 3+ times
- ☐ 4 - TOTAL DEPENDENCE: Full assistance every time
- ☐ 8 - Activity did not occur OR unknown.

What is the client's ADL count?

10. How many ADL impairments does the client have (Count or Total)? Musr answer for NAPIS.

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1.D.2.B. HEALTH RELATED QUESTIONS: Functional Needs: IADL Checklist

1. 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 does not occur or Unknown

2. 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

3. 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

4. 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

5. 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

6. 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

7. 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

8. 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

9. 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

10. How many IADL impairments does the client have (Count or Total)? Must answer for NAPIS

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What is the client's IADL count?

Enter any additional comments regarding IADLs.

1.D.2.C. RELATED QUESTIONS: Functional Needs: ADL/IADL Unmet Needs

ADL/IADL Comments: Identify unmet needs if any.

1.D.3. HEALTH RELATED QUESTIONS: Emotional Health (Answer these questions for the last 30 days)

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. Have you felt satisfied with your life?

- ☐ A - Yes
- ☐ B - No
- ☐ C - No response

4. Have you had a change in sleeping patterns?

- ☐ A - Yes
- ☐ B - No
- ☐ C - No response

5. Have you had a change in appetite?

- ☐ A - Yes
- ☐ B - No
- ☐ C - No response

6. Are you bothered by little interest or pleasure in doing things?

- ☐ A - Yes
- ☐ B - No
- ☐ C - No response

7. Have you thought about harming yourself?

- ☐ A - Yes
- ☐ B - No

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...

1.D4. HEALTH RELATED QUESTIONS: Cognitive Functioning

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

ASSESSOR ACTION: If HEALTH issues refer to Doctor or Home Health Agency. 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.

1.E. 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 well due to problems with biting/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 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.

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

- ☐ A - Yes
- ☐ B - No

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

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

1.F. 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
- [ ] 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 - Med High-Tech services
- [ ] L - Traumatic Brain Injury waiver
- [ ] M - 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 (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 Program
- [ ] 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 discount
- [ ] PP - VPharm (VHAP pharmacy)
- [ ] RR - Emergency Response System (PERS)
- [ ] 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
- [ ] 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 - 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
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- [ ] PP - VPharm (VHAP Pharmacy)
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- [ ] SS - SSI
- [ ] TT - Veterans Benefits
- [ ] UU - Weatherization
- [ ] VV - Assistive Devices

1.G. 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: Estimate the client's gross monthly income from the current poverty level range.

$

5. Is the client's gross monthly income level below the national poverty level at time of assessment?

- [ ] A - Yes
- [ ] B - No
- [ ] C - Don't know

Current year used for Poverty

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

1.H.1. FINANCIAL RESOURCES: Monthly Income

1.a.1. Client's monthly social security income.

$

1.a.2. The monthly social security income of the client's spouse.

$

1.b.1. Client's monthly Supplemental Security Income (SSI)

$

1.b.2. Monthly Supplemental Security Income (SSI) 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.

$

1.H.2. FINANCIAL RESOURCES: Monthly Expenses

2a. Specify the client's monthly rent.

$

2a2. Specify the client's monthly mortgage.

$

2b. Specify the client's monthly property tax.

$

2c. Specify the client's monthly heat bill.

$

2d. Specify the client's monthly utilities bill.

$

2e. Specify the client's monthly house insurance cost.

$

2f. Specify the client's monthly telephone bill.

$

2g. Enter the monthly amount of medical expense the client incurs.

$

2h1. Describe other expense

_____

_____

_____

_____

2h2. Monthly amount of other expense

$

1.H.3. FINANCIAL RESOURCES: Savings/Assets

3a1. What is the name of the bank/institution where the client's checking account is located?

3a2. What is the client's checking account number?

3a3. What is the client's checking account balance?

$

3b1. What is the name of the bank/institution where the client's primary savings account is located?

3b2. What is the client's primary savings account number?

3b3. What is the client's primary savings account balance?

$

3c1. What is the source of Stocks/Bonds/CDs resources?

3c2. What is the amount from Stock/Bonds/CDs resource?

$

3d1. What is the name of the bank/institution where the client's burial account is located?

3d2. What is the client's burial account number?

3d3. What is the client's burial account balance?

$

3e1. Name of the client's life insurance company? (if multiple companies enter in note)

3e2. Client's life insurance policy number?

3e3. Face value of the client's life insurance policy?

$

3e4. What is the cash surrender value of the client's life insurance policy?

$

3f1. What is the name of the bank/institution where the client's other account #1 is located?

3f2. What is the client's other account number #1?

3f3. What is the client's other account #1 balance?

$

3g1. What is the name of the bank/institution where the client's other account #2 is located?

3g2. What is the client's other account number #2?

3g3. What is the client's other account #2 balance?

$

1.H.4. FINANCIAL RESOURCES: Health Insurance

4a1. Does the client have Medicare Part A hospital insurance?

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

4a2. What is the effective date of the client's Medicare Part A coverage?

_____/_____/_____

4a3. What is the client's Medicare Part A claim number?

_____

4a4. What is the client's monthly Medicare part A premium?

$

4b1. Does the client have Medicare Part B medical insurance?

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

4b2. What is the effective date of the client's Medicare Part B coverage?

_____/_____/_____

4b3. What is the client's Medicare B policy number?

_____

4b4. What is the client's monthly Medicare B premium?

$

4c1. Does the client have Medicare C health insurance?

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

4c2. What is the name of the client's Medicare C company/plan?

_____

4c3. What is the effective date of the client's Medicare Part C plan?

_____/_____/_____

4c4. What is the client's Medicare Part C plan premium?

$

4d1. Does the client have Medicare Part D drug coverage?

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

4d2. What is the name of the client's Medicare D company/plan?

_____

4d3. What is the effective date of the client's Medicare Part D coverage?

_____/_____/_____

4d4. What is the client's Medicare Part D premium?

$

4e1. Does the client have Medigap supplemental insurance?

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

4e2. What is the name of the client's Medigap health insurer?

_____

_____

_____

_____

4e3. What is the client's monthly Medigap premium?

$

4f1. Does the client have LTC health insurance?

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

4f2. What is the name of the client's LTC health insurer?

_____

_____

_____

_____

4f3. What is the client's monthly LTC premium?

$

4g1. Does the client have other health insurance?

- [ ] A - Yes
- [ ] B - No
- [ ] C - Don't know

4g2. Enter the name of the client's other health insurance carrier, if applicable.

_____

4g3. What is the client's other monthly premium?

$

4h1. Does the client have VPharm insurance?

- ☐ A - Yes
- ☐ B - No

4h2. What is the effective date of VPharm insurance?

_____/_____/_____

1.H.5. FINANCIAL RESOURCES: Comments

Comment on the client's current financial situation.

_____

_____

_____

_____

1.H6. 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

1.I. "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 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 reporters must file a report of abuse...Enter comments..

_____

_____

_____

_____

Title :

Date

Title :

Date