Resident Assessment

A.0. INDIVIDUAL IDENTIFICATION

1a. Client's **first** name

1b. Client's **last** name

2. RCH/ALR facility name

3. Admission date
_ _/_ _/_ _

4. Specify type of assessment or the reason for the assessment
- ☐ A. Admission assessment
- ☐ B. Significant change in status assessment
- ☐ C. Reassessment
- ☐ D. Other

If Other is answered above. What is other?

5. Date of assessment (this is the assessment reference date)
__ _/_ _/_ _

A.1. DEMOGRAPHIC INFORMATION

1. Client's gender
☐ Male ☐ Female

2. Client's date of birth
_ _/_ _/_ _

3. Client's Social Security Number
_ _-_ _-_ _

3a. Unique ID# for client (DOB + last 4 digits SSN)
(12 numbers) (mmddyyyy####)

4. Client's Medicare number (If applicable)

4a. Client's Medicaid number (If applicable)

5. Name of client's other health insurance carrier, if applicable

6. Client's primary care physician

7a. Name of the client's secondary care physician

7b. Name of any other physician(s)

8. Client's primary language
- ☐ E - English
- ☐ L - American Sign Language
- ☐ F - French
- ☐ B - Bosnian
- ☐ D - Armenian
- ☐ G - German
- ☐ I - Italian
- ☐ S - Spanish
- ☐ P - Polish
- ☐ T - Portuguese
- ☐ M - Romanian
- ☐ R - Russian
- ☐ C - Chinese
- ☐ V - Vietnamese
- ☐ O - Other

9. If Other is checked above, what is the other language?

10. Marital status
- ☐ A - Single
- ☐ B - Married
- ☐ C - Civil union
- ☐ D - Widowed
- ☐ E - Divorced

10a. Client's spouse/partner

10b. Spouse's/Partner's emergency contact number

11. Previous residence
- ☐ A. House
- ☐ B. Assisted Living (AL/RC with 24 hour supervision)
- ☐ C. Private apartment in Senior housing
- ☐ D. Residential care home
- ☐ E. Nursing home
- ☐ F. Other

12. Client's location prior to entering the facility
☐ A. Acute care hospital ☐ B. Other

13a. Emergency **contact 1**

13b. Relationship to client

13c. Street address or PO Box of emergency contact 1

13d. City/town of emergency contact 1

13e. State of emergency contact 1

13f. Zip code of emergency contact 1

13g. Home phone number of emergency contact 1

13h. Cell phone number of emergency contact 1

13i. Work phone number of emergency contact 1

14a. Emergency **contact 2**

14b. Relationship to client

14c. Street address or PO Box of emergency contact 2

14d. City/town of emergency contact 2

14e. State of emergency contact 1

14f. Zip code of emergency contact 1

14g. Home phone number of emergency contact 2

14h. Cell phone number of emergency contact 2

14i. Work phone number of emergency contact 2

15a. Does the client have a legal guardian?
☐ A. Yes ☐ B. No

15b. Name of legal guardian

15c. Home phone number of the legal guardian

15d. Work phone number of the legal guardian

16a. Does client have a power of attorney?
☐ A. Yes ☐ B. No

16b. Name of power of attorney

16c. Home phone number of power of attorney

16d. Work phone number of power of attorney

17a. Does client have a representative payee?
☐ A. Yes ☐ B. No

17b. Name of representative payee

17c. Home phone number of representative payee

17d. Work phone number of representative payee

18a. Does the client have a DPOA for health care?
☐ A. Yes ☐ B. No

18b. Name of DPOA for health care

18c. Home phone number of DPOA for health care

18d. Work phone number of DPOA for health care

19a. Is the client receiving case management services?
☐ A. Yes ☐ B. No

19b. Name of the contact person (case manager) at the agency that provided service to client during the past six months

19c. Telephone number of the agency that provided services (case management) to client during the past six months

20a. Does client have any Advanced Directives?
☐ A. Yes ☐ B. No

20b. For those items with supporting documentation in the medical record, check all that apply.
☐ A. Do not resuscitate
☐ B. Living will
☐ C. Organ donation

20c. Does the client have a prepaid funeral/burial fund?
☐ A. Yes ☐ B. No

21. Describe the client's allergies, if any.

22. Client's occupation, or what occupation did the client hold longest or have at the time of retirement

23. Client's religious affiliation

24. In the past year, how many times has client stayed overnight in a hospital
☐ A. Not at all
☐ B. Once
☐ C. 2 or 3 times
☐ D. More than 3 times

25a. If the client was hospitalized in the past year, what was the **starting** date of **1st** hospitalization
_ _/_ _/_ _

25b. If the client was hospitalized in the past year, what was the **ending** date of **1st** hospitalization
_ _/_ _/_ _

26a. If the client was hospitalized in the past year, what was the **starting** date of **2nd** hospitalization
_ _/_ _/_ _

26b. If the client was hospitalized in the past year, what was the **ending** date **2nd** hospitalization
_ _/_ _/_ _

B.1. CUSTOMARY ROUTINE

1. Select all that apply regarding client's customary routine
☐ A. Stays up late at night (e.g., after 9 pm)
☐ B. Naps regularly during day (at least 1 hour)
☐ C. Goes out 1+days a week
☐ D. Stays busy with hobbies, reading or fixed daily routine
☐ E. Spends most of time alone or watching TV
☐ F. Moves independently indoors (with appliances, if used)
☐ G. Use of tobacco products at least daily
☐ H. Unpleasant mood in morning
☐ I. Use of alcoholic beverages at least weekly
☐ J. Restless, nightmares, disturbed sleep
☐ K. Usually attends church, temple, synagogue (etc.)
☐ L. Daily animal companion/presence
☐ M. Bathing in PM
☐ N. In bedclothes much of day
☐ O. Wakens to toilet all or most nights
☐ P. Has irregular bowel movement pattern
☐ Q. Showers for bathing

☐ R. Sponge bath
☐ S. Tub bath
☐ T. Distinct food preferences
☐ U. Eats between meals all or most days
☐ V. Unknown-Client/family unable to provide information
☐ W. None of the above

C.1. COGNITIVE PATTERNS

1a. Is the client's **short-term** memory OK (seems/appears to recall after 5 minutes)?
☐ A. Yes ☐ B. No

1b. Is the client's **long-term** memory OK (seems/appears to recall long past)?
☐ A. Yes ☐ B. No

2. 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

3. Select the choice that most accurately describes the client's memory and use of information.
☐ A - No difficulty remembering (Does not require directions or reminding from others)
☐ B. Minimal difficulty remembering (Requires direction and reminding 1-3 x day)
☐ C. Difficulty remembering (Requires direction and reminding 4 or more x day)
☐ D. Cannot remember

4. Has the client's cognitive status, skills or abilities changed as compared to status of 90 days ago (or since last assessment if less than 90 days)?
☐ 1. No change
☐ 2. Improved
☐ 3. Deteriorated

D.1. COMMUNICATION/HEARING PATTERNS

1. Indicate the client's current ability to hear (with a hearing appliance, if used).
☐ A. Hears adequately, including normal talk, TV, phone, doorbell
☐ B. Minimal difficulty when not in quiet settings
☐ C. Hears only when the speaker makes special efforts (e.g. louder voice)
☐ D. Highly impaired - absence of useful hearing
☐ E. Using hearing aid
☐ F. Hearing aid present, but not used
☐ G. Other receptive techniques

2. What modes of expression does the client use to make needs be known?
☐ A. Speech
☐ B. Writing messages to express or clarify needs
☐ C. American Sign Language or Braille
☐ D. Signs/gestures/sounds
☐ E. Communication board
☐ F. Other
☐ G. None of the above

3. Indicate the client's current ability to make themselves understood.
☐ A. Understood
☐ B. Usually understood (Difficulty finding words or finishing thoughts)
☐ C. Sometimes understood (Ability is limited to making concrete request)
☐ D. Rarely/never understood

4. Indicate the client's current ability to understand others.
☐ A. Understands
☐ B. Usually understands - may miss some part/intent of message
☐ C. Understands verbal information
☐ D. Understands written information
☐ E. Sometimes understands - responds adequately to simple, direct communication
☐ F. Rarely/never understands

E.1. VISION

1. Indicate the client's current vision quality (with glasses, if they are regularly used).
☐ A. Adequate - sees fine detail, including regular print in newspaper or books
☐ B. Impaired - sees large print, but not regular print in newspaper or books
☐ C. Moderately Impaired - limited vision; not able to see newspaper headlines
☐ D. Highly Impaired - object ID in question, but eyes appear to follow objects
☐ E. Severely Impaired - no vision or sees only light, colors or shapes

2. If the client uses glasses, is he/she able to get them without assistance?
☐ A. Yes ☐ B. No

F.1. MOOD & BEHAVIOR Indicators of depression/anxiety

1. Do you often feel downhearted or blue?
☐ A. Yes ☐ B. No ☐ C. No response

2. Have you been anxious a lot or bothered by nerves?
☐ A. Yes ☐ B. No ☐ C. No response

3. Has the client felt hopeless or helpless?
☐ A. Yes ☐ B. No ☐ C. No response

F.2. MOOD & BEHAVIOR Behavioral Symptoms

1a. **WANDERING**: Moved with no rational purpose, seemingly oblivious to needs or safety.

How often does the client get lost or wander?

☐ 0. Never
☐ 1. Less than daily
☐ 2. Daily

1b. 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

2a. **VERBALLY ABUSIVE**: Others were threatened, screamed at or cursed at.

How often is the client verbally abusive to him/herself or others?

☐ 0. Never
☐ 1. Less than daily
☐ 2. Daily

2b. In **the last 7 days** was the client's verbally abusive behavior symptoms alterable?

☐ 0. Behavior not present OR behavior easily altered
☐ 1. Behavior was not easily altered

3a. **PHYSICALLY ABUSIVE**: Others were hit, shoved, scratched, and assaulted.

How often is the client physically abusive to others?

☐ 0. Never
☐ 1. Less than daily
☐ 2. Daily

3b. In **the last 7 days** was the client's physically abusive behavior symptoms alterable?

☐ 0. Behavior not present OR behavior easily altered
☐ 1. Behavior was not easily altered

4a. **SOCIALLY INAPPROPRIATE**: Made disruptive sounds, noisy, screaming, self-abusive, sexual behavior, hoarding, rummaging, throwing food/feces.

How often does the client exhibit socially inappropriate/disruptive behavior?

☐ 0. Never
☐ 1. Less than daily
☐ 2. Daily

4b. In **the past 7 days**, indicate the frequency and ease of altering the client's behavior of being socially inappropriate/disruptive (e.g. disruptive sounds, noisiness, screaming, self-abusive acts, etc.).

☐ 0. Behavior not present OR behavior easily altered
☐ 1. Behavior was not easily altered

5a. **RESISTS CARE**: Resisted taking medications -injections, ADL assistance, or eating

How often did the client display symptoms of resisting care in the **last 7 days**?

☐ 0. Never
☐ 1. Less than daily
☐ 2. Daily

5b. 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

F.3. MOOD & BEHAVIOR Wandering Risk

1. Select the choice that most accurately describes the client's wandering tendency.

☐ A. Wanders mostly inside
☐ B. Wanders outside, does not get lost
☐ C. Wanders outside, leaves and gets lost
☐ D. Up wandering all or most of the night
☐ E. Does not wander

F.4. MOOD & BEHAVIOR Special programs-Mood-Behavior-Cognitive Loss

1. **BEHAVIORAL SYMPTOM MANAGEMENT PROGRAM:** The resident has ongoing, comprehensive interdisciplinary program to evaluate behaviors. The goal is to understand and implement a plan of care to reduce distressing symptoms.

☐ A. Yes ☐ B. No

2. **BEHAVIORAL MANAGEMENT PROGRAM:** The client has a special program that involves making specific changes in their environment to address mood, behavior, or cognitive patterns.

☐ A. Yes ☐ B. No

3. Has the client been evaluated/assessed by a qualified mental health specialist?

☐ A. Yes ☐ B. No

4. Is the client currently receiving any group therapy?

☐ A. Yes ☐ B. No

F.5. MOOD & BEHAVIOR Change in Behavioral Symptoms

1. Has the client's behavioral status changed as compared to status of 90 days ago (or since last assessment if less than 90 days)?

☐ A. No Change
☐ B. Improved
☐ C. Deteriorated

G.1. PHYSICAL FUNCTIONING Activities of Daily Living

1a. **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 only 1-2 times
☐ 1. SUPERVISION: Oversight/cueing 3+ times or Oversight with physical help 1-2 times
☐ 2. LIMITED ASSISTANCE: Non-wt bearing physical help 3+ times or extensive help 1-2 times
☐ 3. EXTENSIVE ASSISTANCE - Weight bearing help OR full caregiver assistance 3+ times
☐ 4. TOTAL DEPENDENCE - Full caregiver assistance each time activity occurred
☐ 8. ACTIVITY DID NOT OCCUR OR unknown

1b. Select the item for the most support provided of all shifts during the last 7 days, regardless of self performance, for Bed Mobility.

- ☐ 0. No setup or physical help from staff
- ☐ 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

2a. **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 only 1-2 times
- ☐ 1. SUPERVISION: Oversight/cueing 3+ times or Oversight with physical help 1-2 times
- ☐ 2. LIMITED ASSISTANCE: Non-wt bearing physical help 3+ times or extensive help 1-2 times
- ☐ 3. EXTENSIVE ASSISTANCE - Weight bearing help OR full caregiver assistance 3+ times
- ☐ 4. TOTAL DEPENDENCE - Full caregiver assistance each time activity occurred
- ☐ 8. ACTIVITY DID NOT OCCUR OR unknown

2b. Select the item for the most support provided of all shifts during the last 7 days, regardless of self performance, for Transfer.

- ☐ 0. No setup or physical help from staff
- ☐ 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

3a. **Locomotion in residence (MOBILITY):** During the past 7 days, how would you rate the client's ability to perform MOBILITY? (Moving between locations in home. If in wheelchair, self-sufficiency once in wheelchair)

- ☐ 0. INDEPENDENT: No help or oversight or help only 1-2 times
- ☐ 1. SUPERVISION: Oversight/cueing 3+ times or Oversight with physical help 1-2 times
- ☐ 2. LIMITED ASSISTANCE: Non-wt bearing physical help 3+ times or extensive help 1-2 times
- ☐ 3. EXTENSIVE ASSISTANCE - Weight bearing help OR full caregiver assistance 3+ times
- ☐ 4. TOTAL DEPENDENCE - Full caregiver assistance each time activity occurred
- ☐ 8. ACTIVITY DID NOT OCCUR OR unknown

3b. Select the item for the most support provided of all shifts during the last 7 days, regardless of self performance, for locomotion in residence (mobility).

- ☐ 0. No setup or physical help from staff
- ☐ 1. Setup help only
- ☐ 2. One person physical assist
- ☐ 3. Two plus persons physical assist

4a. **DRESSING**: During the past 7 days, how would you rate the client's ability to perform DRESSING? (Putting on, fastening, taking off clothing)

- ☐ 0. INDEPENDENT: No help or oversight or help only 1-2 times
- ☐ 1. SUPERVISION: Oversight/cueing 3+ times or Oversight with physical help 1-2 times
- ☐ 2. LIMITED ASSISTANCE: Non-wt bearing physical help 3+ times or extensive help 1-2 times
- ☐ 3. EXTENSIVE ASSISTANCE - Weight bearing help OR full caregiver assistance 3+ times
- ☐ 4. TOTAL DEPENDENCE - Full caregiver assistance each time activity occurred
- ☐ 8. ACTIVITY DID NOT OCCUR OR unknown

4b. Select the item for the most support provided of all shifts during the last 7 days, regardless of self performance, for Dressing

- ☐ 0. No setup or physical help from staff
- ☐ 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

5a. **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 only 1-2 times
- ☐ 1. SUPERVISION: Oversight/cueing 3+ times or Oversight with physical help 1-2 times
- ☐ 2. LIMITED ASSISTANCE: Non-wt bearing physical help 3+ times or extensive help 1-2 times
- ☐ 3. EXTENSIVE ASSISTANCE - Weight bearing help OR full caregiver assistance 3+ times
- ☐ 4. TOTAL DEPENDENCE - Full caregiver assistance each time activity occurred
- ☐ 8. ACTIVITY DID NOT OCCUR OR unknown

5b. Select the item for the most eating support provided of all shifts during the last 7 days, regardless of self performance, for Eating

- ☐ 0. No setup or physical help from staff
- ☐ 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

6a. **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 only 1-2 times
- ☐ 1. SUPERVISION: Oversight/cueing 3+ times or Oversight with physical help 1-2 times
- ☐ 2. LIMITED ASSISTANCE: Non-wt bearing physical help 3+ times or extensive help 1-2 times
- ☐ 3. EXTENSIVE ASSISTANCE - Weight bearing help OR full caregiver assistance 3+ times
- ☐ 4. TOTAL DEPENDENCE - Full caregiver assistance each time activity occurred
- ☐ 8. ACTIVITY DID NOT OCCUR OR unknown

6b. Select the item for the most support provided of all shifts during the last 7 days, regardless of self performance, for Toilet Use

- ☐ 0. No setup or physical help from staff
- ☐ 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

7a. **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 only 1-2 times
- ☐ 1. SUPERVISION: Oversight/cueing 3+ times or Oversight with physical help 1-2 times
- ☐ 2. LIMITED ASSISTANCE: Non-wt bearing physical help 3+ times or extensive help 1-2 times
- ☐ 3. EXTENSIVE ASSISTANCE - Weight bearing help OR full caregiver assistance 3+ times
- ☐ 4. TOTAL DEPENDENCE - Full caregiver assistance each time activity occurred
- ☐ 8. ACTIVITY DID NOT OCCUR OR unknown

7b. Select the item for the most support provided of all shifts during the last 7 days, regardless of self performance, for Personal Hygiene

- ☐ 0. No setup or physical help from staff
- ☐ 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

8a. **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 or oversight or help only 1-2 times
- ☐ 1. SUPERVISION: Oversight/cueing 3+ times or Oversight with physical help 1-2 times
- ☐ 2. LIMITED ASSISTANCE: Non-wt bearing physical help 3+ times or extensive help 1-2 times
- ☐ 3. EXTENSIVE ASSISTANCE - Weight bearing help OR full caregiver assistance 3+ times
- ☐ 4. TOTAL DEPENDENCE - Full caregiver assistance each time activity occurred
- ☐ 8. ACTIVITY DID NOT OCCUR OR unknown

8b. Select the item for the most support provided of all shifts during the last 7 days, regardless of self performance, for Bathing.

- ☐ 0. No setup or physical help from staff
- ☐ 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

9a. **ADAPTIVE DEVICES**: During the last 7 days how would you rate the client's ability to manage putting on and/or removing braces, splints, prosthesis, and other assistive devices.

- ☐ 0. INDEPENDENT: No help or oversight or help only 1-2 times
- ☐ 1. SUPERVISION: Oversight/cueing 3+ times or Oversight with physical help 1-2 times
- ☐ 2. LIMITED ASSISTANCE: Non-wt bearing physical help 3+ times or extensive help 1-2 times
- ☐ 3. EXTENSIVE ASSISTANCE - Weight bearing help OR full caregiver assistance 3+ times
- ☐ 4. TOTAL DEPENDENCE - Full caregiver assistance each time activity occurred
- ☐ 8. ACTIVITY DID NOT OCCUR OR unknown

9b. Select the item for the most support provided of all shifts during the last 7 days, regardless of self performance, for removing braces, splints or other assistive devices.

- ☐ 0. No setup or physical help from staff
- ☐ 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

10a. **STAIR CLIMBING**: During the past 7 days, how would you rate the client's ability to perform stair climbing.

- ☐ 0. INDEPENDENT: No help or oversight or help only 1-2 times
- ☐ 1. SUPERVISION: Oversight/cueing 3+ times or Oversight with physical help 1-2 times
- ☐ 2. LIMITED ASSISTANCE: Non-wt bearing physical help 3+ times or extensive help 1-2 times
- ☐ 3. EXTENSIVE ASSISTANCE - Weight bearing help OR full caregiver assistance 3+ times
- ☐ 4. TOTAL DEPENDENCE - Full caregiver assistance each time activity occurred
- ☐ 8. ACTIVITY DID NOT OCCUR OR unknown

10b. Select the item for the most support provided of all shifts during the last 7 days for stair climbing. If they did not go up and down stairs, indicate their ability to do so without help.

- ☐ 0. No setup, done without help
- ☐ 1. Setup help only, uses devices
- ☐ 2. With assistance
- ☐ 3. Did not, and has no ability to

G.2. PHYSICAL FUNCTIONING Body Control

1a. Is client bed-bound?

☐ A. Yes ☐ B. No

1b. Does the client have an unsteady gait?

☐ A. Yes ☐ B. No

1c. Does the client have hemiplegia or hemiparesis?

☐ A. Yes ☐ B. No

1d. Amputations?

☐ A. Yes ☐ B. No

G.3. PHYSICAL FUNCTIONING Modes of Locomotion

Select all appliances or assistive devices the client uses for locomotion, on and off the unit.

- ☐ A. Cane/walker/crutch
- ☐ B. Wheeled self
- ☐ C. Wheelchair primary mode of locomotion
- ☐ D. Other person wheeled
- ☐ E. None of the above

G.4. PHYSICAL FUNCTIONING Modes of Transfer

1. Select all appliances or assistive devices the client uses in transferring in and out of bed or chair and for bed mobility.
   - ☐ A. Bedfast all or most of time
   - ☐ B. Lifted manually
   - ☐ C. Bed rails used for bed mobility or transfer
   - ☐ D. Lifted mechanically
   - ☐ E. Transfer aid (e.g. slide board, trapeze, cane, walker, brace)
   - ☐ F. None of the above

G.5. PHYSICAL FUNCTIONING Self Performance in ADLs

1. Client's ADL self-performance status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days).
   - ☐ A. No Change
   - ☐ B. Improved
   - ☐ C. Deteriorated

G.6. PHYSICAL FUNCTIONING Instrumental Activities of Daily Living

1a. **SHOPPING**: During the past 7 days, how would you rate the client's ability to perform **SHOPPING**
   - ☐ 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

1b. Indicate the highest level of shopping support provided in the last 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

2a. **TRANSPORTATION** During the past 7 days, and considering all episodes, how would you rate the client's ability to perform **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

2b. Indicate the highest level of transportation support provided in the last 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

3a. **MONEY MANAGEMENT:** During the past 7 days, how would you rate the client's ability to perform **MONEY MANAGEMENT**
   - ☐ 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

3b. Indicate the highest level of money management support provided in the last 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

4a. **MEAL PREPARATION:** During the past 7 days, how would you rate the client's ability to perform **MEAL PREPARATION**
   - ☐ 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

4b. Indicate the highest level of meal prep support provided in the last 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

5a. **PHONE:** During the past 7 days, how would you rate the client's ability to use the **TELEPHONE**
   - ☐ 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

5b. Indicate the highest level of phone use support provided in the last 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

6a. **LIGHT HOUSEWORK**: During the past 7 days, how would you rate the client's ability to perform **LIGHT HOUSEKEEPING**

- ☐ 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

6b. Indicate the highest level of housekeeping support provided in the last 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

7a. **MANAGING MEDICATIONS:** During the past 7 days, how would you rate the client's ability to perform **MANAGING MEDICATIONS**

- ☐ 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

7b. Indicate the highest level of medications support provided in the last 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

8a. **HEAVY HOUSEWORK:** During the past 7 days, how would you rate the client's ability to perform **HEAVY HOUSEWORK**

- ☐ 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

8b. Indicate the highest level of household maintenance support provided in the last 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

9a. **LAUNDRY:** During the past 7 days, how would you rate the client's ability to do his or her own **LAUNDRY**

- ☐ 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

9b. Indicate the highest level of laundry support provided in the last 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

10a. **EQUIPMENT MANAGEMENT:** During the past 7 days, how would you rate the client's ability to **MANAGE EQUIPMENT** reliably and safely. (Includes only oxygen, IV/infusion therapy, enteral/parenteral nutrition equipment/supplies.)

- ☐ 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

10b. Indicate the highest level of care of equipment support provided in the last 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

G.7. PHYSICAL FUNCTIONING: ADL-IADL Rehabilitation

1. ADL and IADL functional rehabilitation or improvement potential (check all that apply)

- ☐ A. Client believes they are capable of increased independence with some ADLs
- ☐ B. Staff believes client is capable of increased independence with some ADLs
- ☐ C. Client able to perform tasks/activity but is very slow
- ☐ D. Difference in ADL Self-Performance or Support, comparing mornings to evenings
- ☐ E. Special equipment
- ☐ F. Task segmentation
- ☐ G. ADL/IADL skills training
- ☐ H. None of the Above

2. Does the client require an Assistive Device/Adaptive Equipment?

☐ A. Yes ☐ B. No

3. Some or all of ADL activities were broken into subtasks during last 7 days so that Client could perform them

☐ A. Yes ☐ B. No

G.8. PHYSICAL FUNCTIONING: Skills Training

Enter the number of days in last 30 days that client received skill training for at least 15 minutes/day

Number of days of Skill Training in:

A. MEAL PREPARATION.
B. TELEPHONE USE
C. LIGHT HOUSEWORK
D. LAUNDRY
E. MANAGING INCONTINENCE
F. MANAGING CASH
G. MANAGING FINANCES
H. MANAGING SHOPPING
I. SHOPPING
J. TRANSPORTATION
K. MEDICATION MANAGEMENT

G.9. PHYSICAL FUNCTIONING: Devices needed

1. Does the client need any of the following devices or equipment?
   - ☐ A. Eyeglasses
   - ☐ B. Hearing aid
   - ☐ C Cane
   - ☐ D. Walker
   - ☐ E. Wheelchair
   - ☐ F. Assistive eating devices
   - ☐ G. Assistive dressing devices
   - ☐ H. Dentures
   - ☐ I. Other

   If other is checked above, list other devices needed.

H.1. CONTINENCE IN LAST 14 DAYS

1. 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)
   - ☐ 0. Continent: complete control
   - ☐ 1. Usually continent: 1 time a week or less incontinent
   - ☐ 2. Occasionally incontinent: 2 or more times a week but not daily
   - ☐ 3. Frequently incontinent: incontinent daily but some control present
   - ☐ 4. Incontinent: inadequate control, multiple daily episodes
2. What is the current state of the client's bowel continence (in the last 14 days)? Client is continent if control of bowel movement with appliance or bowel continence program.
   - ☐ 0. Continent: complete control
   - ☐ 1. Usually continent: 1 time a week or less incontinent
   - ☐ 2. Occasionally incontinent: 2 or more times a week but not daily
   - ☐ 3. Frequently incontinent: incontinent daily but some control present
   - ☐ 4. Incontinent: inadequate control, multiple daily episodes

H.2. CONTINENCE IN LAST 14 DAYS: Appliances and Programs

1. Select all that apply regarding the client's use of incontinence appliances and programs.
   - ☐ A. Any scheduled toileting plan
   - ☐ B. Bladder retraining program
   - ☐ C. External (condom) catheter
   - ☐ D. Indwelling catheter
   - ☐ E. Intermittent catheter
   - ☐ F. Did not use toilet room/commode/urinal
   - ☐ G. Pads/briefs used
   - ☐ H. Enemas/irrigation
   - ☐ I. Ostomy present
   - ☐ J. None of the above

H.3. CONTINENCE IN LAST 14 DAYS: Change in Urinary Continence

1. Has the client's bladder incontinence worsened as compared to last assessment/90 days ago?
   - ☐ 1. No Change
   - ☐ 2. Improved
   - ☐ 3. Deteriorated

I.1. DIAGNOSIS

1. Client's **primary** diagnoses.

2. Indicate which of the following conditions/diagnoses the client currently has.
   - ☐ A. Aphasia
   - ☐ B. Cerebral palsy
   - ☐ C. Non-Alzheimer's dementia
   - ☐ D. Traumatic brain injury
   - ☐ E. Emphysema/COPD/asthma
   - ☐ F. Renal failure
   - ☐ G. Respiratory disease
   - ☐ H. Quadriplegia
   - ☐ I. Drug resistance (MRSA/VRE)
   - ☐ J. Breathing disorders
   - ☐ K. Nausea/vertigo
   - ☐ L. None of the Above

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 of the above
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
   - ☐ H. Shortness of breath
   - ☐ I. Syncope (fainting)
   - ☐ J. Unsteady gait
   - ☐ K. Vomiting
   - ☐ L. End Stage Disease
   - ☐ M. None of the above
5. Inactive but relevant health conditions?

J.1. ORAL/NUTRITIONAL STATUS

1. How tall is client in **inches** without shoes.

2. How much does client weigh in pounds without shoes.

3. Has the client lost or gained weight in the past 6 months?
   ☐ A. Lost ☐ B. Gained ☐ C. No change/not applicable
4. Select all that apply for nutritional approaches.
   - ☐ A. Parenteral/IV
   - ☐ B. Feeding tube
   - ☐ C. On a planned weight change program
   - ☐ D. Therapeutic diet
   - ☐ E. Mechanically altered diet
   - ☐ F. Dietary supplement between meals
   - ☐ G. Noncompliance with diet
   - ☐ H. None of the above

4a. List if any restricted foods.

5. Select all that apply with regards to the client oral and dental status.
   - ☐ A. Debris (soft, easily movable substances) in mouth prior to going to bed at night
   - ☐ B. Has dentures or removable bridge
   - ☐ C. Some/all natural teeth lost, does not have or use dentures or partial plate
   - ☐ D. Broken, loose, or carious teeth
   - ☐ E. Inflamed gums (gingiva); swollen/bleeding gums; oral abscesses; ulcers or rashes
   - ☐ F. Daily cleaning of teeth/dentures or daily mouth care by client or staff
   - ☐ G. None of the above

K.1. SKIN CONDITION ulcers

STAGE 1 = Persistent area of skin redness that does not disappear when pressure relieved

STAGE 2 = Partial thickness of skin lost, abrasion, blister, or shallow crater

STAGE 3 = Full thickness of skin lost, deep crater

STAGE 4 = exposed muscle or bone

1a. How many Stage 1 ulcers does the client currently have?
   - ☐ 0. Zero
   - ☐ 1. One
   - ☐ 2. Two
   - ☐ 3. Three
   - ☐ 4. Four or more

1b. How many Stage 2 ulcers does the client currently have?
   - ☐ 0. Zero
   - ☐ 1. One
   - ☐ 2. Two
   - ☐ 3. Three
   - ☐ 4. Four or more

1c. How many Stage 3 ulcers does the client currently have?
   - ☐ 0. Zero
   - ☐ 1. One
   - ☐ 2. Two
   - ☐ 3. Three
   - ☐ 4. Four or more

1d. How many Stage 4 ulcers does the client currently have?
   - ☐ 0. Zero
   - ☐ 1. One
   - ☐ 2. Two
   - ☐ 3. Three
   - ☐ 4. Four or more

K.2. SKIN CONDITION Type of ulcer

1a. Specify the highest ulcer stage (1-4) for any pressure ulcers the client has (specify 0 if the client has no pressure ulcers).

K.3. SKIN CONDITIONS Other problems or lesions

1. Indicate which of the following skin problems the client has that requires treatment.
   - ☐ A. Abrasions or Bruises
   - ☐ B. Burns (second of third degrees)
   - ☐ C. Rashes
   - ☐ D. Open lesions other than ulcers, rashes or cuts
   - ☐ E. Skin tears or cuts
   - ☐ F. Other surgical wound site
   - ☐ G. None of the above

K.4. SKIN CONDITIONS foot problems

1a. Does client have foot problems?
   - ☐ A. Yes ☐ B. No

1b. Describe type of foot care needed.

K.5. SKIN CONDITIONS skin treatments

1. Select all skin treatments that the client has received in the past 7 days.
   - ☐ A. Pressure relieving device(s) for bed
   - ☐ B. Turning/repositioning program
   - ☐ C. Ulcer care
   - ☐ D. Nutrition or hydration intervention to manage skin problems
   - ☐ E. Application of dressings (with or without topical medications) other than to feet
   - ☐ F. Application of ointments/medications (other than to feet)
   - ☐ G. Other preventative or protective skin care (other than to feet)
   - ☐ H. None of the above

K.6. SKIN CONDITIONS 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?
   - ☐ A. Yes ☐ B. No

L.1. MEDICATIONS

1. Is the client taking medication? If No, skip to M.1. Special Treatments
   - ☐ A. Yes ☐ B. No
2. Does the client have any problems with taking medications as instructed/prescribed? (proper route)
   - ☐ A. Yes ☐ B. No (**If yes** needs medication administration)
3. Does the client know what his/her medication is for?
   - ☐ A. Yes ☐ B. No (**IF No** needs medication administration)
4. Does the client know how often to take medications?
   - ☐ A. Yes ☐ B. No (**IF No** needs medication administration)
5. Does the client communicate desired effect of medication or unintended side effects of medications?
   - ☐ A. Yes ☐ B. No (**IF No** needs medication administration)
6. Does the client control his/her own prescription medications?
   - ☐ A. Yes ☐ B. No
7. Does the client control his/her own over the counter (OTC) medications?
   - ☐ A. Yes ☐ B. No
8. Record the number of days that injections of any type were received during the last 7 days. Enter 0 if none.

9. How does the client get their injections?
   - ☐ A. Client without assistance
   - ☐ B. Administered/monitored by Professional Nursing Staff
   - ☐ C. Administered/monitored by Lay Person
10. What is the date of the client's medication review by medical provider?

    _ _/_ _/_ _
11. Specify the degree of compliance the client has with medications as prescribed by a physician (both during and between therapy visits).
    - ☐ A. Always compliant
    - ☐ B. Compliant 80% of the time or more
    - ☐ C. Compliant less than 80% of the time
12. Record **the number of days** during last 7 days that the client received **antipsychotic** medication. Enter "0" if not used and "1" for long acting meds used less than weekly.

13. Record the **number of days** during last 7 days that the client received **antianxiety** medication. Enter "0" if not used and "1" for long acting meds used less than weekly.

14. Record the **number of days** during last 7 days that the client received **antidepressant** medication. Enter "0" if not used and "1" for long acting meds used less than weekly.

15. Record the **number of days** during last 7 days that the client received **Hypnotic** medication. Enter "0" if not used and "1" for long acting meds used less than weekly.

16. Record the **number of days** during last 7 days that the client received **diuretic** medication. Enter "0" if not used and "1" for long acting meds used less than weekly.

M.1. SPECIAL TREATMENTS: Procedures & Programs

1. Medical treatments that the client received during the last 14 days.
   - ☐ A. Chemotherapy
   - ☐ B. Dialysis
   - ☐ C. IV medication
   - ☐ D. Intake/output
   - ☐ E. Monitoring acute medical condition
   - ☐ F. Ostomy care
   - ☐ G. Oxygen therapy
   - ☐ H. Radiation
   - ☐ I. Suctioning
   - ☐ J. Tracheostomy care
   - ☐ K. Transfusions
   - ☐ L. Ventilator or respirator
   - ☐ M. None of the Above

M.2. SPECIAL TREATMENTS: Other providers/services

1a. 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. Medicaid Waiver (HB/ERC)
   - ☐ K. Medicaid Hi-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
   - ☐ R. AAA Case management
   - ☐ S. Community action program (CAP)
   - ☐ T. Community mental health services
   - ☐ U. Dementia respite grant/NFCSP Grant
   - ☐ V. Elder 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
   - ☐ DD. Housing and supportive services
   - ☐ 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. VHAP pharmacy
   - ☐ QQ. V-script
   - ☐ RR. Emergency Response System
   - ☐ SS. SSI
   - ☐ TT. Veterans benefits
   - ☐ UU. Weatherization
   - ☐ VV. Assistive Devices

M.3. SPECIAL TREATMENTS: Rehabilitation/Restorative Care

FOR THE FOLLOWING QUESTIONS: Enter the number of days that the following rehabilitation practices were provided to the client for more than or equal to 15 minutes per day in the last 7 days. Enter 0 as none or less than 15 minutes a day.

Enter the **number of days** for:

a. RANGE OF MOTION (Passive)
b. RANGE OF MOTION (Active)
c. SPLINT OR BRACE ASSISTANCE
d. BED MOBILITY
e. TRANSFER
f. WALKING
g. DRESSING-GROOMING
h. EATING-SWALLOWING
i. AMPUTATION-PROSTHESIS
j. COMMUNICATION
k. OTHER AREAS

M.4. SPECIAL TREATMENTS Visiting Nurse home health therapies

1. Is the client undergoing any treatments/therapies?
   ☐ Yes ☐ No
   If no skip to M.5.
2. What is the frequency of nurse visit?
   - ☐ A. Less than once a week
   - ☐ B. Once a week
   - ☐ C. More than once a week
3. What is the frequency of nurse aide visit?
   - ☐ A. Less than once a week
   - ☐ B. Once a week
   - ☐ C. More than once a week
4. What is the frequency of therapist visit?
   - ☐ A. Less than once a week
   - ☐ B. Once a week
   - ☐ C. More than once a week

M.5. SPECIAL TREATMENTS Devices & Restraints

a. Rate the extent **that full bed rails** on all open sides of bed were used in the past 7 days as a means of restraining the client.

- ☐ 0. Not Used
- ☐ 1. Used less than daily
- ☐ 2. Used daily

b. Rate the extent that **trunk restraints** were used in the past 7 days as a means of restraining the client.

- ☐ 0. Not Used
- ☐ 1. Used less than daily
- ☐ 2. Used daily

c. Rate the extent that **other types of side rails** (e.g., half rail, one side) were used in the past 7 days as a means of restraining the client.

- ☐ 0. Not Used
- ☐ 1. Used less than daily
- ☐ 2. Used daily

d. Rate the extent that the client was placed in a **chair with a lap board that prevented rising** in the past 7 days as a means of restraining the client.

- ☐ 0. Not Used
- ☐ 1. Used less than daily
- ☐ 2. Used daily

e. Rate the extent that **limb restraints** were used in the past 7 days as a means of restraining the client.

- ☐ 0. Not Used
- ☐ 1. Used less than daily
- ☐ 2. Used daily

f. Rate the extent that **chemical restraints (drugs)** were used in the past seven days as a means of restraining the client.

- ☐ 0. Not Used
- ☐ 1. Used less than daily
- ☐ 2. Used daily

N.1. SIGNATURES

1a. Type in name of person completing assessment and sign below if other than RN.

_____

Signature

2. Type in name of Agency/Facility the assessor works for

3. Signature of client or legal representative? (Optional)

4. Facility Registered Nurse (signature required)

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected/coordinated this information on the dates specified

_____

Signature

5. What is the date that the assessment was signed as complete?

_ _/_ _/_ _

O. Intake for AOA (for AAA case managed clients)

O.1: DEMOGRAPHIC INFORMATION

1a. 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

1b. Enter client's self-described ethnic background if OTHER

2. Do you live:

- ☐ A. Lives Alone
- ☐ B. Lives with spouse only
- ☐ C. Lives with spouse and child
- ☐ D. Lives with child (not spouse)
- ☐ E. Lives with others (not spouse or children)

3. Are you currently employed?

- ☐ A. Yes - full/part time not specified
- ☐ B. No

4. How many related people reside together in your household (counting yourself)?

- ☐ A. One person
- ☐ B. Two people
- ☐ C. Three people
- ☐ D. Four or more people
- ☐ E. Information unavailable

5. What is the total income of client's household per month?

$

6. Specify the client's monthly income.

$

6a. Is client's income level below the national poverty level?

☐ A. Yes ☐ B. No

O.2. THE NSI DETERMINE Your Nutritional Health Checklist

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

☐ A. Yes ☐ B. No

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

☐ A. Yes ☐ B. No

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

☐ A. Yes ☐ B. No

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

☐ A. Yes ☐ B. No

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

☐ A. Yes ☐ B. No

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

☐ A. Yes ☐ B. No

7. Do you eat alone most of the time?

☐ A. Yes ☐ B. No

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

☐ A. Yes ☐ B. No

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

- ☐ A. Yes ☐ B. No
- ☐ L. Yes, lost 10 pounds
- ☐ G. Yes, gained 10 pounds

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 ☐ B. No

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

☐ A. Yes ☐ B. No

Total score of Nutritional Risk Questions.

Date:

Title: