THE MODEL ASSESSMENT TOOL

The Assessment: Assessment is a structured process of interviews which is used to identify the participant's abilities, needs, preferences and supports; determine eligibility for programs and services; and provide a sound basis for developing the care plan. A secondary purpose of the assessment is to provide the participant with a good understanding of the program and the services that can be provided and of what is expected of him/her. Assessments are conducted in partnership with the participant and his/her family, guardian, or other supports as appropriate.

Purpose of the Assessment Tool: This assessment tool is designed to be a comprehensive examination of an individual's life situation which includes their deficits and their strengths. This tool is part of the assessment process that is on-going throughout the period of time that an individual receives long term care services. The assessment process includes constant re-evaluation of the person's situation in order to change services provided to meet changing needs.

This assessment tool was developed to enable care managers to perform a thorough assessment that will result in a comprehensive care plan that is individualized and considers the participant's preferences. The objective of this tool is to learn enough about the individual to create with the participant a comprehensive plan, meeting his/her needs and enhancing his/her life.

Part of the assessment process is the inclusion of addendum tools which have more in depth questions to determine additional services or to prompt the referral to professionals outside of the care management team. These addenda are used on an individual basis and will provide a greater amount of information.

Completing the Tool: It is recommended that a social worker and a nurse complete the assessment as a team. Due to the length of this inquiry, it may be advisable to conduct the assessment in two separate sessions. If a county has limited staff time and cannot perform this assessment in two separate sessions, it is suggested that the nurse and social worker divide the survey and conduct their sessions separately. If the tool is used in this manner, it is recommended that a meeting take place in order for the two assessors to discuss the findings and any follow-up that is necessary.

Please note that specific instructions for each page are printed on the facing page.
The assessment face sheet is designed to gather pertinent information and keep it within easy reach of the care manager for quick reference. It is also designed to provide a short review of information about the participant if it is needed and the care manager is not available.

Much of the information on the face sheet could/should have been obtained in the initial intake procedure.

**Participant Information**

Record the participant information as completely as possible. If information is unknown, write unknown. Do not leave any spaces blank. The emergency contact person and the guardian may be the same person. Write "same" in the second line.

**Person's Disability(ies)**

Check all that apply.

**Program(s)**

Check all that apply. If the person is not currently on a program but will be applying to one or more programs, check those that are anticipated to be providing services to the participant.

**Formal Supports**

Complete as accurately as possible with complete addresses and phone numbers. Complete addresses and phone numbers do not need to be obtained at the time of the assessment but do need to be filled in later. If the individual has no dentist, etc. write "none" and note that this may be an area to pursue.
## ASSESSMENT FACE SHEET

Name: (Last, First, M.I.)

Birthdate

Address: Zip Telephone County

Marital Status: Sex: ☐ female ☐ male Ethnic Origin:
☐ married ☐ widowed ☐ American Indian ☐ Hispanic
☐ divorced ☐ single ☐ Asian ☐ Black
☐ separated ☐ Veteran: ☐ yes ☐ no ☐ White

Other

Primary language (if other than English)

Emergency Contact Person:

Name/Relationship Address Telephone

Guardian/Durable POA/Protective Payee/POA for Health Care/Primary Caregiver:

Name Address Telephone

Name Address Telephone

Chapter 55: ☐ yes ☐ no
Chapter 51: ☐ yes ☐ no
1.67 Referral ☐ yes ☐ no

If yes, name of Court _______________________________

Court ordered care ☐ yes ☐ no

Social Security Number: _______________ Medicare Number: _______________

Medicaid Number/Start Date: _______________ Other Insurance: _______________

Person’s Disability(ies): Program(s):
☐ frail elderly ☐ SHC ☐ CIP II
☐ chronic alcohol or drug abuse ☐ CIP 1A ☐ CSP
☐ developmentally disabled ☐ COP ☐ COP W
☐ serious or persistent mental illness ☐ CIP 1B ☐ CSLA
☐ physically disabled ☐ MA Case ☐ Other
☐ Alzheimer’s/dementia Management

Living Arrangement:

☒ own home/apartment ☐ lives alone
☒ relative’s home/apartment ☐ w/spouse
☒ friend’s home/apartment ☐ lives with others:
☒ CBRF/AFH #beds ______
☒ Supervised/semi-super. apartment
☒ Other ____________________

Household Composition:

Formal Supports

<table>
<thead>
<tr>
<th>NAME</th>
<th>ADDRESS</th>
<th>TELEPHONE</th>
<th>FREQ. OF CONTACT</th>
<th>OTHER INFO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>primary physician</td>
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<tr>
<td>dentist</td>
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<td>specialist</td>
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DATE COMPLETED ______________________________________
LONG TERM SUPPORT ASSESSMENT

Complete the first section with an explanation of the reason for the referral. If others are present at the assessment please indicate who they are and their relationship to the participant. When asking the assessment questions, direct them to the participant. If someone other than the participant answers the question, re-direct the question to the participant (unless they are physically incapable) and politely request that the individual answer the question.

Note where you receive conflicting information or if the participant is unable to answer a question.

**Advance Directives:** Be sure the participant understands what an advance directive is and understands the difference between living wills, power of attorneys, and durable power of attorney for health care.
**LONG TERM SUPPORT ASSESSMENT**

Date of Assessment: __________________________ □ Initial Assessment □ Assessment Update

Referral Source: ___________________________ Date of Referral: ___________________________

Name/Agency/Relationship to participant Address Telephone

Situation Precipitating Referral: __________________________________________________________

Assessment Completed
By: ___________________________________________________________________________

Others present at assessment (relationship): ______________________________________________

Additional information obtained from: ____________________________________________________

Level of care on Functional Screen: ________________ COP Rights given: □ yes □ no

**ADVANCE DIRECTIVE:** Have you been advised about Advance Directives? □ yes □ no
If yes, have you completed one and where is it kept? _______________________________________
If no, has the Advance Directive pamphlet been given to you? □ yes □ no

What family, friends or reliable resources can and/or do provide help to you? Please list the activity provided.

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<th>NAME</th>
<th>RELATIONSHIP</th>
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</table>
PHYSICAL HEALTH

It is important to obtain as complete a physical assessment as possible. This will help you to involve medical professionals in the care plan if it is indicated. You will also become knowledgeable about areas to focus prevention efforts. It is recommended that this section be completed by a nurse. If the individual is in the hospital or has had a recent examination by a physician, medical records may be used in addition to the information obtained in this section. Do not use any medical information in lieu of asking the participant the questions directly.

Part of a good health assessment is determining if the individual is happy with their health care provider and what preferences they may have. If a participant is unhappy with his/her provider or feel she/he doesn't have choices in his/her health care, it may lead to non-compliance with health care recommendations.
PHYSICAL HEALTH

It is recommended that a nurse complete this section along with the section on ADLs and IADLs. If completed by the care manager, no need to duplicate top section.

Name: (Last, First, M.I.) Birthdate ____________________________

Address: ____________________________ Zip ____________________________ Telephone ____________________________ County ____________________________

Physicians name: ____________________________ Clinic: ____________________________ Hospital: ____________________________

Interviewer name ____________________________ Sections completed: (circle) Physical health ADLS IADLS

<table>
<thead>
<tr>
<th>List previous, present or potential health problems</th>
<th>Under Treatment</th>
<th>Comments:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
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When did you last see your doctor? _______________ What was this for? ____________________________________________

How often do you see your physician? _________________________________________________________

Are you happy or unhappy with your medical care? (circle) If unhappy, explain ____________________________

Have you been hospitalized in the last year? □ yes □ no If yes, how many times? _______________

What was this for? ________________________________________________________________________

What hospital do you go to? _________________________________________________________________

Have you ever been admitted to a nursing home, CBRF, AFH, other? □ yes □ no When? _____________

Where? ____________________________ Why were you there? ____________________________________________

2
Medications/Treatments/Services/Supplies

When listing the medications, it is helpful to ask to see the medications and where they are kept. Take each medication individually and ask the participant the accompanying questions. Be sure to include over-the-counter medications. Note any indications that the person does not understand or is not taking the medication properly. If the individual does not administer their own medications, be sure to ask these questions of the provider.

If you are able to look at the medication bottles, check the expiration dates. Follow-up with the physician and/or home health providers to double check the accuracy of the medications being taken.
MEDICATIONS (including over-the-counter)/TREATMENT/SERVICES/SUPPLIES

For each medication ask the person: What is the medication for? What are the side effects of this medication? How and when do you take this medication?

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage/Frequency</th>
<th>Client’s Understanding/Compliance</th>
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<tbody>
<tr>
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Nurse: If medications indicate the need for blood levels, are blood levels being done as needed? □ yes □ no

Are you allergic to any medications? □ yes □ no What?

How do you obtain your medications?

Do you use a pillbox or other reminder? □ yes □ no What?

Do you use tobacco? □ yes □ no Do you drink caffeine? □ yes □ no

Do you currently drink or have you ever drank alcohol? currently: □ yes □ no in the past: □ yes □ no
   How much do you drink each day____________________ week____________________

Do you use or have you ever used street drugs? □ yes □ no

Which ones and how much?

Assessor: If this information or other info indicates a need for more complete AODA data, see addendum tool

Are you currently receiving any services? (HHA, PT, OT, ST, etc.) □ yes □ no If yes, describe what those are and who provides these services:

______________________________________________________________________________

______________________________________________________________________________

Do you routinely purchase any medical supplies? □ yes □ no What?

______________________________________________________________________________
**Question:** In general, how would you say your health is?

Record the participant's response to this question. This question provides a good insight into the participant's own view of their health and is a key to how the person views their current ability to manage their health. If the participant is currently in the hospital, record how she/he would have responded before admission and how she/he responds now.

**Physical Systems Breakdown**

Ask the participant each of the accompanying questions, i.e. "How is your eyesight?" Allow the participant to answer the question and use the prompts that follow if the answer is not complete enough to provide you with the information requested. Question and note any instances in which your observation differs from the participant's response. For example, The participant responds that their eyesight is fine and you observe the participant wearing glasses. If the participant is blind in one eye - note which eye. Do the same with ears.

If the participant (particularly an elderly person) has not had a vision, hearing or dental exam in the past two years it is an indication that they may need to be examined. (A younger person may not need a vision or hearing exam.)
In general, how would you say your health is? ____________________________________________

What is your height? _______ What is your weight? _______

Has your weight gone up or down in the past year? □ yes □ no

Assessor: if yes, please complete nutritional assessment and/or depression screen

Vision – How is your eyesight?
□ Client has no problem □ Impairment is not corrected
□ Client is blind: (circle) one eye both eyes
□ Client wears corrective lens: glasses: □ yes □ no contacts: □ yes □ no
□ Date of last exam: □ Client needs exam

Comments: ____________________________________________________________

Hearing – How is your hearing?
□ Client has no problem □ Client wears hearing aid: □ yes □ no
□ Impairment is not corrected □ Client experiences ringing in the ears
□ Client is deaf: (circle) one ear both ears
□ Date of last exam: □ Client needs exam

Comments: ____________________________________________________________

Dental – Do you have any dental concerns?
□ Client has own teeth □ Client wears dentures
□ Client needs dentures
□ Client has a dental disease: describe

□ Date of last exam: □ Client needs exam

Comments: ____________________________________________________________

Respiratory – Do you have any difficulty breathing?
□ Client has no difficulty □ Client experiences sinus problems
□ Client reports experiencing shortness of breath (SOB) □ Client has frequent cough
□ Client is currently on oxygen □ Client is observed experiencing SOB
  Usage/number of liters per minute ____________
  Where is it obtained?

Comments: ____________________________________________________________
Cardiovascular – Have you experienced any heart problems?

- □ Client has no difficulty
- □ Client experiences edema (swelling)
- □ Client experiences chest pain
- □ Client experiences leg pain (intermittent claudication)

Pulse ___________ Blood Pressure ___________

Comments: _______________________________________

Skin – Do you have any open sores or skin problems?

- □ Client has no difficulty
- □ Client wears hearing aid: □ yes □ no
- □ Client has ulcers, open wounds or bruises
- □ Client has a rash or skin disease(s). Describe: _______________________________________

Comments: _______________________________________

Nutrition – Are there certain foods that your doctor says you should or should not eat? (i.e., no salt, diabetic)?

What?

- □ Client has no difficulty
- □ Client requires nutritional supplements
- □ Client is unwilling or unable to follow diet
- □ Client’s food or fluid intake must be monitored

How would you describe your appetite: □ excellent □ good □ fair □ poor

Comments: _______________________________________

Elimination – Do you have any problems with your bowels or bladder?

- □ Client has no difficulty
- □ Client experiences bladder incontinence. When? __________ How often? __________
- □ Client experiences bowel incontinence. When? __________ How often? __________
- □ Client has colostomy or ileostomy
- □ Client wears protective pads
- □ Client has recently experienced a change in elimination; Describe: _______________________________________

Are any of the following a problem to you?

- □ constipation □ diarrhea □ frequent urination at night

Do you need or use any of the following?

- □ commode □ urinal □ toilet railings □ bed pan □ catheter □ elevated toilet seat □ other

Comments: _______________________________________

Assessor: additional nutrition assessment is found in addendum section

5
Reproductive Health – What is the date of your last physical exam? ______________________________

Female:  Date of last pelvic exam __________  pap smear __________
Date of last breast exam __________  monthly self breast exam  □ yes  □ no

Male:  Date of last prostate exam __________
Date of last testicular exam __________
monthly self testicular exam  □ yes  □ no

Comments: ____________________________________________________________________________

Musculo Skeletal – Do you have any problems with the following:

□ muscle weakness  □ swelling  □ joint stiffness  □ pain  □ muscle cramps

Comments: ____________________________________________________________________________

What is your activity/exercise level?

Assessor: please record participant’s perception

□ bed bound  □ inactive or sits most of the time  □ moderately active  □ very active

Comments: ____________________________________________________________________________

Central Nervous System – Do you experience any of the following?

□ tremors  □ headaches  □ seizures  □ trouble speaking  □ abnormal muscle movements  □ loss of sensation/feeling
□ other: ____________________________________________________________________________

Comments: ____________________________________________________________________________

<table>
<thead>
<tr>
<th>Miscellaneous</th>
<th>yes</th>
<th>no</th>
<th>Explain:</th>
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<tbody>
<tr>
<td>Do you have any problems with your feet?</td>
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<tr>
<td>Do you experience weakness, fatig or dizziness?</td>
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<tr>
<td>Have you experienced a fall within the last year?</td>
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<tr>
<td>Do you have a history of stroke?</td>
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</table>
Physical Health (con 't)

Note any difficulty in communicating needs and what services, supports, etc. may help the person become more independent.

The last question in this section about follow-up required, is designed to prompt the assessor to think about ways to improve the health and independence of the person being assessed. Anything noted in this section should be included on the care plan.
If the client has identified visual and/or auditory impairments, or communication problems, please describe how they make their needs known: (i.e., gestures, sign language, interpreter, communication board, etc.)

_________________________________________________________________________

What does the individual require in the area of health teaching about their illness, disability, medications or treatments? Describe what is needed and follow-up required:

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________
ACTIVITIES OF DAILY LIVING

Completing this section will help the care manager get a good picture of what the participant is able to do for themselves and what assistance is needed or provided. Follow the code guide as to what the participant either needs or has and define the code in the comment section. The comment section is designed to specifically state what the participant needs and/or has in the way of services. Any line that has a code other than A should have a comment. Note any areas that the assistance is not enough to maintain the participant in the environment they choose to be in. This should then be a part of the care planning process.

The questions in this section are designed to elicit a narrative response by the participant. The assessor may need to prompt with additional questions to obtain the information required. It is also helpful if this information can be corroborated by either a care provider or individual knowledgeable about the participants abilities.

Again, be thinking about ways in which this individual may become more independent by receiving teaching, therapy or assistive devices. You need not complete this section immediately but may wish to make notes so as not to forget to provide any follow-up that is required.
## ACTIVITIES OF DAILY LIVING

**CODE:**
- **A** = NO DIFFICULTY
- **B1** = ADAPTIVE AID NEEDED
- **B2** = ADAPTIVE AID USED
- **C1** = ASSISTANCE NEEDED
- **C2** = ASSISTANCE USED

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
<th>CODE</th>
<th>COMMENTS (please describe code)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you use utensils and eat without help?</td>
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<tr>
<td>How do you get in and out of bed and/or a chair?</td>
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<tr>
<td>How do you dress and undress yourself?</td>
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<tr>
<td>How do you get in and out of the bath or shower?</td>
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<tr>
<td>How do you prepare your bath, wash and dry yourself?</td>
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<td></td>
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<tr>
<td>How do you complete toilet activities?</td>
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<tr>
<td>Do you have difficulty walking up and down a flight of stairs?</td>
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<tr>
<td>How far are you able to walk without becoming tired or requiring assistance?</td>
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</table>

Would this person benefit from any teaching or therapy to become more independent? Describe: __________

What assistive devices could this person use to be more independent? Describe: _________________

--

8
INSTRUMENTAL ACTIVITIES OF DAILY LIVING

This section will also provide you with a picture of the participant's abilities. Be thinking of adaptive aids the individual could benefit from and/or consultation with physical therapists, occupational therapists, etc.

If a participant answers a question by stating that they are unable to do that particular activity any longer, be sure to ask if they would like to be involved in that activity and make a note to discuss that particular area when determining the services the participant will receive. For example, if the participant responds that they can no longer participate in grocery shopping because they can't see the labels well enough, but would like to continue with this activity, you may want to pursue a vision exam or providing a support worker to go shopping with the individual.
## INSTRUMENTAL ACTIVITIES OF DAILY LIVING

**CODE:**
- A = NO DIFFICULTY
- B1 = ADAPTIVE AID NEEDED
- B2 = ADAPTIVE AID USED
- C1 = ASSISTANCE NEEDED
- C2 = ASSISTANCE USED

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
<th>CODE</th>
<th>COMMENTS (please describe code)</th>
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<tbody>
<tr>
<td>How are your meals prepared? (complete nutritional addendum if warranted)</td>
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<tr>
<td>How do you complete the housekeeping and outside chores?</td>
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<tr>
<td>How do you do your grocery shopping?</td>
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<tr>
<td>How do you travel in a van, taxi, bus or car?</td>
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<td>How do you answer the telephone or call the telephone operator?</td>
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<tr>
<td>How do you clean your teeth, comb your hair and (shave) yourself?</td>
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<tr>
<td>How do you handle your bill paying, banking, etc.?</td>
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<tr>
<td>How do you do your laundry?</td>
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</table>

**FOR PEOPLE USING WHEELCHAIRS:**

Describe your ability to independently propel your own wheelchair, both inside and outside your home:

Describe how you transfer (i.e., from bed to chair, chair to toilet):

Describe your chair: age _____  □ prescribed by physician  □ fitted  □ cushion
□ special attachments  □ needs evaluation

**Would this person benefit from any teaching or therapy to become more independent? Describe:**

**What assistive devices or services could this person use to be more independent? Describe:**

---

9
DECLARATION OF INCOME AND ASSETS

This form is the same as the form which may have been completed to determine initial eligibility for services. If a form has been completed, you may need to update it only and/or complete any missing information. If a form has previously been completed and signed, this form does not need to be signed.

If the individual is applying for the Medicaid-Waiver, it is important to obtain complete information on the monthly medical expenses to put on the medical/remedial expenses part of the cost sharing form. Also, your county may allow some or all of these expenses to apply to an individual's cost share for Community Options Program services.

If the participant does not have an irrevocable funeral trust fund and needs to spend down to qualify for services, this area should be pursued.
# DECLARATION OF INCOME & ASSETS

Name: ____________________________________

## MONTHLY EARNED INCOME

<table>
<thead>
<tr>
<th>CLIENT</th>
<th>SPOUSE</th>
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<tbody>
<tr>
<td>1. Before tax wages or salary</td>
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</tbody>
</table>

## ALL OTHER INCOME

| 1. Social Security |        |
| 2. SSI/SSI-E |        |
| 3. Veteran’s Pension |        |
| 4. Pensions/Annuities |        |
| 5. Interest/Dividend Income |        |
| 6. Other: (i.e., estates/trusts, net rental income, workman’s compensation, unemployment compensation, alimony, etc.) |        |

**TOTAL ALL OTHER INCOME _______**

**TOTAL ASSETS ________________**

Income received for children in the home (i.e., child support, soc. security, SSI, etc.) ______________________________

--------------------------------------------------------------------

## EXPENSES

<table>
<thead>
<tr>
<th></th>
<th>Yours</th>
<th>Spouse’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child support or family support ordered to be paid monthly:</td>
<td></td>
<td></td>
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<tr>
<td>Maintenance or alimony court ordered to be paid monthly:</td>
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</table>

List **average monthly** out-of-pocket expenses which could be considered medically related to the person’s condition. Medically related expenses should be interpreted broadly. The following are examples of what should be counted, but the list is not complete: medications, medical supplies, equipment, payments on outstanding medical bills, caregivers, excess energy costs related to a medical condition, health insurance premiums, doctor/dentist/hospital bills (not covered by a third party), MA co-payments, hearing aids, wheelchair expenses, diapers, bed pads, etc.

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</table>

Do you have an irrevocable funeral trust fund? ________

Have you or your spouse sold or given away property (such as land, stocks, bonds, cash, etc.,) within the last thirty months including transfers of property to children, relatives or other persons? □ YES □ NO

I have tried to give true and accurate information. I understand that the agency may request more detailed and documented information later.

Date: ____________________ Signature: ______________________________________________________

Relationship to participant
SOCIAL HISTORY/RESOURCES

It is very important to obtain complete information about the informal supports available to the participant as it is the goal of community programs to support and enhance services to individuals, not supplant what is currently being provided. It is also important to learn if informal supports will continue and/or need to be increased. Be aware of indications of caregiver stress and burden. You may wish to complete the addendum “Family Screen” or additional caregiver burden screen.

When asking the participant to tell you about their personal history, allow them to freely share what they choose. You may wish to prompt them with the examples provided. Help the individual to focus on positive life experiences. Help them to see where they have struggled and coped with difficult situations in the past.
Please tell me about your personal history. (i.e., birthplace, youth, maiden name, education, work, veteran, marriage(s), etc.)

Please describe your family of origin. (i.e., parents, brothers, sisters, etc.)

<table>
<thead>
<tr>
<th>Living</th>
<th>Deceased</th>
<th>Name/Relationship</th>
<th>City/State</th>
<th>Phone</th>
<th>Has contact how often?</th>
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</tbody>
</table>

Do you have any children? If so, please list:

<table>
<thead>
<tr>
<th>Living</th>
<th>Deceased</th>
<th>Name/Relationship</th>
<th>City/State</th>
<th>Phone</th>
<th>Has contact how often?</th>
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</thead>
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</tbody>
</table>
Social History/Resources (con ’t)

When asking questions about social activities be sure to identify barriers to participation and address those issues in the care plan.
Please describe what a typical day is like for you now:

________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________

How is this different from what it used to be?  
________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________

What do you enjoy doing around your home? (i.e., gardening, pets, crafts, cooking, t.v., reading, etc.) 
________________________________________________________________________________________________________________________________________________

What activities do you enjoy outside of your home? (i.e., church, sporting events, concerts, dining, movies, etc.)
________________________________________________________________________________________________________________________________________________

Are you currently employed either paid or volunteer? □ yes □ no If no, would you like to be? □ yes □ no  
What activities have you always wanted to try but have not been able to?
________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________

Do you now or have you in the past, belonged to any groups? □ yes □ no If yes, what?
________________________________________________________________________________________________________________________________________________

What do you usually do for holidays?
________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________

Do you regularly visit anyone? □ yes □ no If no, is there a transportation problem? □ yes □ no
________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________

[Assessor: please determine the transportation problem]

Do other people regularly visit you? □ yes □ no If yes, who?
________________________________________________________________________________________________________________________________________________

[Assessor: determine connection and importance of visitor(s)]

Is there anyone who routinely checks on you to be sure you are okay? □ yes □ no If no, is there someone you would like to check on you routinely? □ yes □ no  Who?
________________________________________________________________________________________________________________________________________________

Do you regularly talk to anyone over the phone? □ yes □ no If yes, who?
________________________________________________________________________________________________________________________________________________
How would you describe your social activity level?  □ isolated □ socially active □ uninvolved by choice

Would you like to increase the amount of your social activity?  □ yes □ no
   If yes,  a) what would you like to do? ________________________________________________
   b) what is stopping you from doing this? ____________________________________________

When you have a decision to make, do you make it yourself or do you often have someone help you? ______

________________________________________________________________________________________

What aspect of your life are you most proud of? ________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
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What other information would you like to share with me that will help me to know you better? _____________
________________________________________________________________________________________
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________________________________________________________________________________________
PHYSICAL ENVIRONMENT

When completing this section of the assessment it is helpful to compare your observations with what the participant says. It may help to look around the home with the participant's permission or even have the participant show you around. This will give you an opportunity to observe the participant's mobility as well as how they have adapted to their environment.

**Be aware of your own personal biases.** If the house looks run down and you may not want to live in it, it doesn't mean the participant does not want to live there.
PHYSICAL ENVIRONMENT

How long have you lived in your current residence? _______________________ Are you happy here? ________ If not, why not?

Do you own or rent? _______ Landlord (if applicable) ____________________________________________

Do you feel safe living here? ________________________________________________

<table>
<thead>
<tr>
<th>Check which items are currently a problem for you</th>
<th>Describe the Problem/Repair Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uphold of building</td>
<td></td>
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<tr>
<td>Hot water</td>
<td></td>
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<tr>
<td>Comfortable temperature</td>
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<tr>
<td>Stove/Refrigerator</td>
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<tr>
<td>Telephone</td>
<td></td>
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<tr>
<td>TV/Radio</td>
<td></td>
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<tr>
<td>Washer/Dryer</td>
<td></td>
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<tr>
<td>Trouble with neighbors/roommate</td>
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<tr>
<td>Isolated location</td>
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<tr>
<td>Access barriers inside home</td>
<td></td>
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<tr>
<td>Access barriers outside home</td>
<td></td>
</tr>
<tr>
<td>Substantial repairs needed</td>
<td></td>
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<tr>
<td>Lack of space</td>
<td></td>
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<tr>
<td>Housing too expensive</td>
<td></td>
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<tr>
<td>Client must move</td>
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<tr>
<td>Tub/Shower</td>
<td></td>
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<tr>
<td>Difficulty with landlord</td>
<td></td>
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<tr>
<td>Plumbing</td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
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</tbody>
</table>

Additional Comments: ____________________________________________________________

______________________________________________________________________________

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______________________________________________________________________________
EMOTIONAL FUNCTIONING

This section is often difficult to talk about with a participant because of the emotion involved. Participants may not be completely honest with you about their feelings. Be sure to note differences between what the participant states he/she feels and the affect they show. It is important for the assessor to feel comfortable with questions in this section. If you don't feel comfortable, the participant won't feel comfortable. You may wish to try them out on a co-worker before actually going through the interview. If the participant does become emotional, give him/her time to compose himself/herself and let them know it is all right to express emotions. Don't rush through the questions or ignore the emotion or the participant may feel they have done something wrong.
EMOTIONAL FUNCTIONING

Have you had any major changes or losses in your life in the past year? (i.e., death of a loved one, loss of job, divorce, illness, moving, retirement, change in financial status)  □ yes  □ no

Comments: ____________________________________________________________

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_______________________________________________________
Do you ever feel that life isn’t worth living? □ yes □ no
If yes,  
a) Do you ever feel that you want to die? ____________________________
b) Do you ever think about suicide? _________________________________
c) When does that happen? _______________________________________
d) How often? _______________________________________________

Do you sometimes have trouble getting along with people you are close to? □ yes □ no
If yes,  
a) What kinds of things cause the trouble? __________________________
b) What do you usually do about it? ________________________________

How would you rate your mental or emotional health at the present time?
□ excellent □ good □ fair □ poor

Are you receiving any mental health treatment or services now? □ yes □ no  If yes, what?

ADDITIONAL COMMENTS: (Is further mental health assessment needed?) _______________________________
This section is also difficult for assessors to conduct. It is important to ask the questions in a straightforward manner so as to not bias the results. It is helpful to tell the person the test is given to all people going through the assessment process. It may also be helpful to simply ask the participant for permission to ask them questions about their memory. In most cases they will agree. If the participant should refuse to answer the questions, note their refusal and move to the next section. It is also helpful to practice this test before actually giving it to a participant.

Nurses are often trained in completing the cognitive assessment. If you have a nurse complete the physical assessment, you may also wish to have them complete this section.
COGNITIVE FUNCTIONING

SHORT MENTAL STATUS QUESTIONNAIRE (SPMSQ)
E. Pfeiffer (1975)

Instructions: Ask questions 1-10 in this list and record all answers. Ask questions 4a only if patient does not have a telephone. Record total number of errors based on ten questions.

1. What is the date today? _______________________________________________________________

2. What day of the week is it? __________________________________________________________

3. What is the name of this place? _______________________________________________________

4. What is your telephone number? ______________________________________________________

4a. What is your street address? __________________________________________________________
   (ask only if patient doesn't have a telephone)

5. How old are you? _____________________________________________________________________

6. When were you born? __________________________________________________________________

7. Who is the President of the U.S. now? _____________________________________________________

8. Who was President just before him? _______________________________________________________

9. What was your mother's maiden name? _____________________________________________________

10. Subtract 3 from 20 and keep subtracting from each new number, all the way down.

   TOTAL NUMBER OF ERRORS

<table>
<thead>
<tr>
<th>Errors</th>
<th>Description</th>
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<tbody>
<tr>
<td>0 - 2</td>
<td>Intact Intellectual Functioning</td>
</tr>
<tr>
<td>3 - 4</td>
<td>Mild Intellectual Impairment</td>
</tr>
<tr>
<td>5 - 7</td>
<td>Moderate Intellectual Impairment</td>
</tr>
<tr>
<td>8 - 10</td>
<td>Severe Intellectual Impairment</td>
</tr>
</tbody>
</table>
PERSON'S PREFERENCES

This section is meant to be a review of the information obtained from the completion of the assessment tool. As the care plan is developed it is important to know exactly what the participant's preferences are in relation to each of the categories listed.

Please be aware that this section should not be limited to what services/supports are available to the individual but rather a means to recording what is important for that person and a way of setting goals for the individual, i.e., if the individual prefers to do their own shopping but is unable to because of mobility problems, this needs to be noted as a way of setting the goal for the individual to become more independent with mobility so that they can participate in the shopping in some manner.

This form may be a helpful way to recap with the participant what was learned in the assessment interview and could be a means to clarify any issues that were not initially made clear.
PERSON'S PREFERENCES
(Describe person's preferences in the following areas)

Living Arrangement: ______________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Service Arrangements: (type, who, frequency)
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Medical Services: ______________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Community Connections: (social, recreational, transportation)
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Is there anything about your cultural/ethnic heritage that is important for us to know?:
_______________________________________________________________________
_______________________________________________________________________

Other: ____________________________________________________________
_______________________________________________________________________
_______________________________________________________________________