## Chapter 11:
## National Family Caregiver Support Program

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## Chapter 11

## National Family Caregiver Support Program

### 11-1: Description of the National Family Caregiver Support Program

The National Family Caregiver Support Program (NFCSP) establishes an infrastructure of program resources and assistance for family caregivers and grandparents or other relative caregivers. The NFCSP in Tennessee shall be provided in accordance with Title III, Part E, of the Older Americans Act (OAA), as amended in 2006, and TCAD Program and Policy Manual. Grants to States, with State Plans approved under Section 307, shall pay for the Federal share of the cost of carrying out State programs to enable area agencies on aging or entities that such area agencies on aging contract with, to provide a multifaceted system of support services. The NFCSP shall be accessible and provided throughout each of the planning and service areas of Tennessee.

### 11-1-.01: Caregivers

The focus of NFCSP is the caregiver and provides a service delivery system that respond to the needs of the caregiver. **The caregiver is the client in the NFCSP program.** Caregivers include:

(1) Family Caregivers

- (a) Adult family members (age 18 years or older) or other adult informal caregivers providing care to adults age 60 and over and adults with disabilities.
- (b) Adult family members or other adult informal caregivers providing care to individuals of any age with Alzheimer's disease and related disorders and neurological and organic brain dysfunction.

(2) Grandparents and Relative Caregivers

- (a) Grandparents, step-grandparents, or other relatives (not parents) age 55 and older providing care to adults, age 18 to 59, with disabilities
- (b) Grandparents, step-grandparents, or other relatives (not parents) age 55 or older providing care to children under the age of 18 years that:
  - (i) live with a child that is not more than 18 years of age or is an individual with a disability (19-59 years of age with a disability). Disability refers to conditions attributable to mental or physical impairment or to a combination

of mental and physical impairment that results in substantial functional limitations in one or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, economic self-sufficient, cognition functioning, and emotional adjustment [see 42 USC 3002 (8)]

(ii) is the primary caregiver of the child because the biological or adoptive parents are unable or unwilling to serve as the primary caregiver of the child.

(iii) has a legal relationship to the child, such as legal custody or guardianship, or is raising the child informally.

**11-1-.02: Service Components**

The Tennessee Commission on Aging and Disability (TCAD), working in partnership with the nine (9) Area Agencies on Aging and Disability (AAAD) and local community service providers, shall provide five (5) categories of services for caregivers. The number of activities/ contacts/hours/sessions required for each of the 5 categories is indicated in parentheses. The categories are as follows:

(1) Information Services (1 activity)

This service for caregivers provides the public and individuals with information, resources, and services available to the individuals within their community. Information services are activities, such as but not limited to, disseminating publications and conducting media campaigns, directed to a large audience of current and potential caregivers.

(2) Access Assistance

(a) Information and Assistance (1 contact)

This service assists caregivers in obtaining access to the services and resources that are available within the community. To the maximum extent practicable, this service ensures that the individual receives the services needed by establishing adequate follow-up procedures.

(b) Care Management (1 hour)

This service provides assistance either in the form of access or care coordination in circumstances where the care recipient is experiencing diminished functioning

capacities, personal conditions, or other characteristics which require the provision of services by formal service providers or family caregivers. Activities of case management include such practices as assessing needs, developing care plans, authorizing and coordinating services among providers, and providing follow-up and reassessment, as required.

(c) Outreach (1 contact)

This service provides intervention with individuals initiated by an agency or organization for the purpose of identifying potential caregivers and encouraging their use of existing services and benefits.

(3) Individual Counseling, Organization of Support Groups, and Caregiver Training (1 session)

This service is provided to assist the caregivers in the areas of health, nutrition, and financial literacy in order to make decisions and solve problems related to their care giving roles. The services include:

(a) Individual Counseling

Caregiving can be very stressful, both physically and emotionally. Individual counseling allows the caregiver the opportunity to discuss issues related to caregiving such as, but not limited to, identifying signs of caregiver burnout or stress; coping with the emotions such as frustration, feelings of inadequacy, and depression; and, above all, taking care of one's self. A licensed professional counselor should provide individual counseling; however, if a licensed professional counselor is not available, a staff person qualified by training or experience can deliver the service if he/she is supervised by a counselor licensed by the State of Tennessee. The AAADs must have a Licensed Counselor or a counseling agency to which to make a referral if a caregiver is in need of an individual counseling. Licensure can be verified at http://health.state.tn.us/Licensure/index.htm through the Tennessee Department of Health. Licensure includes: Licensed Professional Counselor, Licensed Clinical Social Worker, Licensed Clinical Psychologist, or PhD.

(b) Support Groups

This service offers sessions that allow caregivers the opportunity to discuss their attitudes, feelings, and problem with input from other members of the group; attempt to achieve greater understanding and adjustment; and explore solutions to their problems.

(c) Caregiver Training

This service offers training/education that is designed to assist caregivers with acquiring knowledge and skills that will help them in providing care.

(4) Respite Care

This service offer temporary, substitute supports or living arrangements for care recipients in order to provide a brief period of relief or rest for caregivers. Respite care may include:

(a) in-home respite such as personal care, homemaker services, and sitter service;

(b) respite in a non-residential program such as adult day care;

(c) institutional respite provided by placing the care recipient in an institutional setting such as a nursing home for a short period of time as a respite service to the caregiver; and

(d) summer camps for children.

Transportation of the care recipient to an adult day care center or similar program, such as transporting children to summer camp, may be part of the respite expense.

(5) Supplemental Services

This service is provided on a limited basis to complement the care provided by caregivers. Examples of supplemental services include, but not limited to, home modification, home-delivered meals, medical equipment and supplies, personal emergency response system (PERS), incontinence supplies, and assistive technology. Supplemental services also includes:

(a) Legal assistance that includes counseling as well as training sessions on legal issues should be reported as a supplemental service.

(b) Transportation to medical appointments would be a supplemental service.

**11-1-.03: Priority**

In providing services, priority shall be given to:

(1) caregivers who are adults age 60 and over with the following conditions:

(a) greatest social need caused by non-economic factors which include physical and mental disabilities; language barriers; and cultural, social and geographic isolation (including racial or ethnic status) that restricts an individual's ability to perform normal daily tasks or threatens his/her capacity to live independently; and

(b) greatest economic need resulting from an income level at or below the poverty line (100%) as defined by the Office of Management and Budget and adjusted by the Secretary of Health and Human Services with particular attention to low-income adults age 60 and over who are providing care to adults age 60 and over.

(2) adults age 60 and over providing care to individuals with severe disabilities, including children with severe disabilities;

(3) family caregivers who provide care for adults age 60 and over with Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(4) grandparents or relative caregivers who provide care for children with severe disabilities.

**11-1-.04: Eligibility**

Information, assistance, and counseling can be provided to any caregiver, but Respite and Supplemental Services funded under the NFCSP can be provided only if the **care recipient** meets the definition of frail. Frail means an individual that is determined to be functionally impaired according to the following guidelines;

(1) The care recipient is unable to perform at least two (2) Activities of Daily Living (ADL) without substantial human assistance, including verbal reminding, physical cueing, or supervision; and/or

(2) The care recipient has a cognitive or other mental impairment that requires substantial supervision to prevent the individual from harming him/herself or others. Respite and Supplemental Services that are not supported by Title III-E (and state or local matching funds) are not bound by the eligibility restrictions. Any of the five (5) NFCSP service categories may be provided to grandparents, step-grandparents, and other older relative caregivers caring for a child.

Non-citizens are eligible to receive services through the NFCSP. In accordance with AoA guidelines, non-citizens, regardless of the alien status, should not be banned

from services authorized by the OAA and administered by the AoA based solely on their alien status.

**11-1-.05: Funding Limitations**

(1) It is recommended that in-home respite funding for the caregiver under the NFCSP not to exceed $2,500 annually per individual enrolled after July 1, 2014, but shall not exceed a maximum of $3,500 annually per individual without prior approval of the AAAD Executive Director. Reimbursement for in-home services such as personal care, home-maker, home delivered meals and respite shall not exceed the OAA rate of reimbursement (See HCBS chapter for reimbursement rates.)

(2) No AAAD may use more than ten percent (10%) of its award to provide Title III-E services to grandparents or relative caregivers of a child who is not more than 18 years of age. Services provided to grandparents or relative caregivers providing care for adult children with disabilities that are between 19 and 59 years of age shall not be counted against the 10% ceiling for grandparents and other caregivers.

(3) No AAAD may use more than twenty percent (20%) of its award to provide supplemental services. Supplemental services are flexible enhancements to caregiver support programs designed for the benefit of caregivers. Each AAAD can elect supplemental services based on local needs as long as they are included in the Area Plan and approved by TCAD.

**11-1-.06: Administrative Standards**

Funds made available under the NFCSP shall supplement, not supplant, any Federal, State, or local funds expended by a State or unit of general purpose local government (including the AAAD) to provide services described in Title III, Part E, Section 373 of the Older Americans Act.

(1) TCAD shall:

(a) designate a coordinator to implement and oversee program development of the NFCSP statewide.

(b) develop and maintain consistent standards and mechanisms for the NFCSP to be implemented statewide. These standards and mechanisms shall be used to assure the quality of services provided in accordance with the Older Americans Act, Administration of Aging regulations and policies, and TCAD policies and rules.

(c) develop standard individual assessment tools to be used by all AAADs.

(d) collect, maintain, and report information in State Reporting Tool (SRT).

(e) provide training to the family caregiver program staff, as needed.

(f) provide technical assistance, as needed.

(g) assume quality assurance responsibilities for all caregiver programs to ensure compliance with standards, policies, and procedures of TCAD and the Older Americans Act.

(2) At a minimum each AAAD shall:

(a) publicize NFCSP services to ensure that individuals throughout the area know about the availability of the services.

(b) provide caregiver information and referral and screen individuals for caregiver support services.

(c) complete an in-home assessment on individuals whose screening indicates need for respite or supplemental services.

(d) arrange for the provision of individually needed family caregiver services directly and/or through local service providers.

(e) organize new and/or coordinate with existing caregiver support groups and caregiver training events.

(f) have a licensed professional counselor referral source to which caregivers can be referred for individual counseling, if needed.

(g) coordinate NFCSP with other programs and service systems serving individuals with disabilities.

(h) use trained volunteers to expand the provision of the five (5) service components.

(i) attend training planned or approved by TCAD.

(j) ensure appropriate program/financial reporting, billing, and budget reconciliation.

(k) negotiate contracts and provide quality assurance program implementation.

(l) compile, maintain, and report waiting lists of persons requesting caregiver services for which service is not available.

**11-1-.07: Consumer's Right to Self-Determination**

(a) All adult individuals have a right to choose how they will live, as well as where they will live, as long as they are competent to make that decision and able to understand the consequences of their actions.

(b) All adult individuals are presumed legally competent unless they have been deemed in competent by a court.

(c) It is essential to encourage the individual to live in an environment or situation that is safe. The NFCSP is not expected to assist an individual that chooses to continue to live in a situation that is unsafe or to make plans that are unrealistic and unsafe.

(d) Reports to Adult Protective Services (APS) are mandated by state law when "any person" has reasonable cause to suspect abuse, neglect (including self-neglect), or financial exploitation. This includes neighbors, friends, relatives, doctors, dentists, caregiver, agency personnel, etc.
(Adult Protect Act T.C.A. 71-6-103(b) (1)

**11-1-.08: Screening**

When an individual contacts the AAAD for information about available services, he/she will be assessed using the initial screening/intake. If the I&A staff determines the individual to be a caregiver, he/she will be asked screening questions specifically related to his/her needs as a caregiver. I&A staff will also ask questions about the care recipient. The caregiver is placed on the caregiver wait list. I&A staff should code the call under caregiver if the I&A staff talks directly with the caregiver about his/her need to receive services as a caregiver. The caregiver will be referred to the Family Caregiver Support Program.

**11-1-.09: Assessment and Reassessment**

If the screening indicates a caregiver's need for respite or supplemental services, the Caregiver Form 2010a shall be completed. The Social Assistance Management System Independent Living Assessment (SAMS ILA) 2012 shall be completed on the care recipient that should include the following minimum sections:

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

All assessments and reassessments shall be completed in a face-to-face interview in the home with the caregiver.

A reassessment is required at least annually; however, staff should be alert for changes in a caregiver's condition or circumstances that may warrant a reassessment at an earlier date. Follow-up calls should be made quarterly to ensure that the needs of the caregiver are being met. Follow-up calls should be documented in a case note in the record of the caregiver.

Respite and Supplemental services provided through Title III-E must comply with policies and procedures of the service being provided. For example, a caregiver and/or care recipient that receives home-delivered meals through the NFCSP must comply with Nutrition guidelines.

**11-1-.10: Reporting Requirements**

TCAD is required to submit the State Reporting Tool (SRT) on an annual basis that includes data on the NFCSP. The NFCSP is on the federal fiscal year, October 1 through September 30. The NFCSP section of the State Reporting Tool (SRT) shall be submitted quarterly the 20th day of the month following the end of the quarter. When the due date falls on a weekend or holiday, the report will be due on the following business day. Required reports must be submitted to TCAD according to the instructions, schedule, and form(s) provided. The year-end report should include data for the entire fiscal year.

Each AAAD shall maintain program data and client information for each service provided through the NFCSP.

(1) The following demographic data for each caregiver must be entered into the SAMS database in order to count. An aggregate number may not be entered. Demographic data should include the following:

- (i) Name
- (ii) Address
- (iii) Telephone number
- (iv) Age
- (v) Gender
- (vi) Race/ethnicity
- (viii) Rural status (usually determined by the AAAD based on address information)
- (ix) Name and relationship to the care recipient
- (x) Optional: Cell phone number or Email address, if available

(2) The only service that is excluded from entering demographic data is Group Information. For this service, an aggregate number can be entered.

(3) For Individual Counseling, Support Groups, and Caregiver Training, a unit of service is equal to a session. Each caregiver will receive a unit of service for each session he/she attend.

(4) Home-delivered meals served with Title III-E funds may be counted as a Nutrition Services Incentive Program (NSIP) eligible mean **if** the meal:

(a) meets the requirements of the OAA (Title III-C);

(b) is served by an agency that has a grant or contract with TCAD or AAAD; and

(c) is served to an individual qualified for service under Title III of the OAA:

(i) care recipients, who are age 60 and over;

(ii) caregivers, who are age 60 or older; or

(iii) caregivers, regardless of age, that are the spouse of a care recipient who is age 60 or older.

**11-1-.11: Long Distance Caregivers**

There are two (2) types of long distance caregivers:

(1) The caregiver lives within the State of Tennessee and the care recipient lives in another State.

(2) The caregiver lives in another State and the care recipient lives within the State of Tennessee.

Caregiver services may be provided to long distance caregivers whose care recipient resides within the State of Tennessee, if funds are available. However, the decision to provide Respite and Supplemental services to long distance caregivers will be done on a case-by-case basis and must be pre-approved by TCAD. Title III-B or Title III-C in-home services or state funding home and community based services should be considered first if the care recipient is eligible to receive services under those programs. If the caregiver resides in Tennessee and the care recipient resides within another state, the Tennessee AAAD should make a referral to the AAA in the State where the care recipient lives.

**11-1-.12: Volunteers**

Each AAAD shall make use of trained volunteers to expand the provision of the five (5) service components. The AAAD should work in coordination with organizations that have

experience in providing training, placement, and stipends for volunteers or participants (such as organizations carrying out Federal service programs administered by the Corporation for National and Community Service) in community service settings. Such programs include Senior Corps and AmeriCorps (VISTA).

**11-1-.13: Background Checks**

This program must be in compliance with the Background Check Chapter of the TCAD *Program and Policy Manual*.

11-1-.14: **Cost Sharing and Participant Contribution Requirements**

Cost sharing and participant contribution requirements shall be at the discretion of the AAAD. However, if the AAAD chooses to implement cost share, then cost share should be calculated on the care recipient's income with the payment being the responsibility of the caregiver. (See the HCBS chapter for cost share standards.)

# Caregiver Assessment

# Caregiver Form 2010a

## I. Profile

### I.A. Caregiver Identification

1. **What is the date of the assessment?**

   ____/____/_____

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

   - ☐ Initial assessment
   - ☐ Reassessment

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

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

5. **What is the client's first name?**

6. **What is the client's last name?**

7. **What is the client's middle initial?**

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

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

10. **Enter the client's state of residence.**

11. **Enter the client's residential zip code.**

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

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

14. **Enter the client's mailing state.**

15. **Enter the client's mailing ZIP code.**

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

    _____-_____-_____

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

18. **Enter the client's telephone number.**

19. **Alternate telephone number for client**

20. **What is the client's gender?**

    - ☐ Female
    - ☐ Male

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

    ____/____/_____

22. **Enter the age of the client in years.**

    ☐

23. **Select the client's current marital status.**

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

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

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

**25. What is the client's race?**

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

**26. Is the client currently employed?**

- ☐ Full time
- ☐ Part time
- ☐ No

## I.B. Caregiver Profile

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

_____

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

_____

**3. Does the client live with the care recipient?**

- ☐ No
- ☐ Sometimes
- ☐ Yes

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

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

**5. What is the care recipient's status.**

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

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

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

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

_____

_____

_____

_____

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

_____

_____

_____

_____

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

- ☐ No
- ☐ Yes

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

_____

_____

_____

_____

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

- ☐ No
- ☐ Yes

## II. Caregiving Tasks

### II.A. Type of Service

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

- ☐ Yes
- ☐ No

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

- ☐ Yes
- ☐ No

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

- ☐ Yes
- ☐ No

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

- ☐ Yes
- ☐ No

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

- ☐ Yes
- ☐ No

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

- ☐ Yes
- ☐ No

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

- ☐ Yes
- ☐ No

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

- ☐ Yes
- ☐ No

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

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

## III. Impact of Caregiving

### III.A. Caregiver Challenges

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Title : _____ Date _____

Title : _____ Date _____

# Action Plan

# ACTION PLAN

| ☐ Initial | ☐ Review | Individual: | Individual Id: |
|---|---|---|---|

| Individual Phone #: | County: | If NFCSP, Care Recipient Name: |
|---|---|---|

| Physcian's Name: | Physician's #: |
|---|---|
| Emergency Contact: | Phone #: |

## INDIVIDUAL'S NEEDS

*(This section should detail specific in-home support services needed in order to maintain the Individual's independence.)*

| Needs of the Individual | Specific Actions for Addressing Needs | Goals |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## SERVICE AUTHORIZED

| Services Authorized | Funding Source | Provider Name | Frequency and/or Duration | Total Units | Unit Cost | 6 Month or Annual Cost | Auth Date | Start Date | End/ Revision Date |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

| Total Amount of Authorized Services | | Initials of Individual for 1st Page: |
|---|---|---|

| Individual Name: | Individual Id: |
|---|---|

**INFORMAL SUPPORT AND OTHER COMMUNITY SUPPORTS TO INDIVIDUAL**

*(This section should detail services that are being provided by informal supports and other community supports. Support service may include services that already exist and/or services they are willing to provide in order to meet the needs of the individual.)*

| Type of Support to be Provided | Name of Person or Community Resource to Provide Support | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

| Next Review: __ 6 Months __ 12 Months __ Other: _____ Date: | **Effective Date:** |
|---|---|

| Cost Share Required? | ☐ Yes | ☐ No | |
|---|---|---|---|

**I, the Individual or Authorized Representative, have been involved in developing this action plan. I understand that it may be revised as my preferences and needs change and that I will be notified in advance of changes to the service plan. I have been given the option to choose my providers for services.**

| Signature of Individual or Authorized Representative: | Date: |
|---|---|
| Signature of Options Counselor: | Date: |
| Signature of AAAD Authorized Designee: | Date: |

**Appendix C**

# Cost Share Forms

# COST SHARE WORKSHEET

OPTIONS, OAA

Name _____ Date: _____

DOB _____ Id#: _____

1

| | | |
|---|---|---|
| Household Size | 1 | 2 |
| Declared Monthly Income | $0.00 | $0.00 |
| 200% of FBR (*Update yearly*) | $1,442.00 | $ 2,164.00 |
| **Income Subject to Cost Share** | **-$1,442.00** | **-$2,164.00** |

2 Action Plan Estimation (HDM is subject to donation only)

| | Units/Month or Year | Unit Cost | Total |
|---|---|---|---|
| Homemaker | 0 | $ - | $ - |
| Personal Care | 0 | $ - | $ - |
| Monthly or Yearly Cost Estimate for Service | | | $ - |

3 **Cost Share Rate** (Income subject to Cost Share divided by the amount given for the appropriate number in the household)

| | |
|---|---|
| Cost Share Rate: | -50.00% |
| | -50.00% |

| | | |
|---|---|---|
| 1 | $ 2,884.00 | (Update yearly with FBR x 4) |
| 2 | $ 4,328.00 | (Update yearly with FBR x 4) |

4 **Cost Share**

| | |
|---|---|
| $0.00 | Household 1 |
| $0.00 | Household 2 |

Options Counselor _____ Date _____

Note: The amount of cost share cannot exceed 45% of their declared income

Note: If cost share is less then $25/month, the Individual will not be required to pay

If assessed a cost share, 1 copy for Fiscal and original for file

# FINANCIAL RESOURCES-INCOME

| Name: | Id: |
|---|---|

**Income**

| INCOME | Individual | Spouse (if applicable) |
|---|---|---|
| Social Security | | |
| SSI | | |
| Retirement/Pension | | |
| Interest from Savings, CDs, etc | | |
| VA Benefits | | |
| Wages/Salaries/Earnings | | |
| Other (specify) | | |
| **TOTAL** | 0 | 0 |

**Savings/Assets**

| Type of Asset | Amount | Comments |
|---|---|---|
| Checking | | |
| Savings | | |
| CDs | | |
| Other | | |

**Monthly Living Cost**

| SOURCE | AMOUNT PER MONTH | COMMENTS |
|---|---|---|
| Rent/Mortgage | | |
| Heat | | |
| Electric | | |
| Water/Garbage | | |
| Telephone | | |
| C[illegible] | | |
| Property Tax | | |
| Home Insurance/Rental Insurance | | |
| Medical Insurance | | |
| Medications | | |
| Transportation | | |
| Other (specify) | | |
| Other (specify) | | |
| Other (specify) | | |
| Other (specify) | | |
| Other (specify) | | |
| Other (specify) | | |
| Other (specify) | | |
| Other (specify) | | |
| Other (specify) | | |
| Other (specify) | | |
| **TOTAL** | 0 | |

| **Available Income** | 0 | |
|---|---|---|

**Fee Waived: _____ Yes ____ No**

| Options Counselor | | Date: | |
|---|---|---|---|

Comments:

# Missed Visit Report

# MISSED VISIT REPORT

**Individual's Name:** _____ **Id#:** _____

**If NFCSP, Care Recipient Name:** _____ **Id#:** _____

**Provider Agency:** _____ **County:** _____

**Program** *(check one)*: ☐ **OPTIONS** ☐ **NFCSP (Caregiver, Title III-E)** ☐ **OAA (Title III)**

**Dates of Missed Visit:** _____

_____

**Type of Visit:**

☐ Personal Care ☐ Home Delivered Meals ☐ In-Home Respite

☐ Homemaker ☐ Other: _____

**Reason for Missed Visit:**

☐ Individual/Care Recipient had unscheduled appointment

☐ Individual/Care Recipient hospitalized

☐ Individual/Care Recipient refused services

☐ Individual/Care Recipient refused alternate staff member services

☐ Individual/Care Recipient unavailable: ☐ Hospital ☐ Nursing Home ☐ Other:

_____

☐ Knocked – No Response: Contact Person Notified/Response: _____

☐ Called – No Answer: Contact Person Notified/Response: _____

☐ Scheduling error

☐ Hazardous weather

☐ Holiday scheduling – ☐ Provider canceled ☐ Individual/Care Recipient canceled

☐ Provider unable to provide service because: _____

_____

Additional Provider Comments: _____

_____

**Signature of Agency Representative:** _____ **Date:** _____

AAAD Use Only: ☐ Provider Liable ☐ Consumer Liable ☐ No Fault

**FAX/SCAN WITHIN 5 BUSINESS DAYS OF MISSED VISIT TO AAAD**

# Signature Page

## SIGNATURE PAGE

**Individual's Name:** _____ **Individual's ID:** _____

☐ **AGE DECLARATION** – I am unable to provide proof of age and I declare that I am 60 years of age or older and that my date of birth, _____ (Month/Day/Year), is correct to the best of my knowledge.

☐ **ASSESSMENT** – I certify that the information provided to the Options Counselor regarding my medical, social and financial circumstances is accurate and complete. I understand that if it is determined at a later date that the information collected is incorrect, my eligibility for services may be affected.

☐ **CHOICE OF PROVIDERS** – I have been offered a choice of service providers from a list of available companies in my county for each service I am authorized to receive. I understand that it is my choice as to whom I want to provide the in-home services.

☐ **PRIVACY PRACTICES AND INDIVIDUAL RIGHTS AND RESPONSIBILITIES** – By signing this form I acknowledge that I have received a copy of the Notice of Privacy Practices and a copy of the Individual Rights and Responsibilities. I also acknowledge that I understand the information provided in the Notice of Privacy Practices and the Rights and Responsibilities.

☐ **RELEASE OF INFORMATION FOR STATISTICAL REPORTING** – I understand that the information collected will not be identified with me personally. It may be used in statistical reports. I give my permission to use the information for statistical reporting.

☐ **REQUEST FOR INTERAGENCY INFORMATION SHARING** – I receive services for more than one program funded through the Tennessee Commission on Aging and Disability and the Area Agency on Aging and Disability. I request the information from my assessment be shared with agencies that would otherwise have to interview me again to collect the same data.

☐ **SERVICES POLICY** – I understand that initiating/continuing services is based upon the availability of funding from State/Federal sources. Additionally, change(s) in Individual circumstances may determine eligibility for an increase or decrease in services.

☐ **TITLE VI** – I understand that I have the right not to be discriminated against on the ground of race, color, or national origin. I understand the procedures for filing a complaint if I feel that I have been discriminated against.

☐ **VOLUNTARY CONTRIBUTIONS** – I understand how to make a voluntary contribution to help pay for the cost of my services paid for by the AAAD. I understand that my contribution can be made anonymously and/or confidentially if that is my preference.

_____ _____

Initials of Individual/Authorized Representative Date

**Individual's Name:** _____ **Individual's ID:** _____

☐ **COST SHARING** – I understand there is a possibility that I will have cost share and that I will be receiving a letter informing me about my cost sharing responsibilities if my income exceeds 200% of the Federal Benefit Rate. I understand that prior to my services starting, I will be informed of my costs, if any.

☐ **RECEIPT OF ADVANCED DIRECTIVE INFORMATION** – I have received written information on my right to formulate advanced directives.

☐ **PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)** – I understand that if I have PERS equipment and I am no longer receiving PERS services that the equipment will be removed from the home at the discontinuation of the service.

☐ **NUTRITION COUNSELING** – I understand that due to identified nutritional risk factors, I have been referred for Nutrition Counseling. ☐ Accept or ☐ Deny

☐ **AUTHORIZATION FOR REFERRAL FOR SERVICES** – I give permission for the Area Agency on Aging and Disability to contact, on my behalf, the agencies or persons listed below and/or on my Action Plan and to release only such information to them as may be needed to determine the level and types of services that I may need. I also grant permission to the receiving agencies to report back regarding services that I may or may not receive and/or any additional information that may significantly reflect on my need for services. This authorization may be revoked at any time by my written statement, and is automatically revoked at my transfer from the agency or at notification of death to include a period of six (6) months.

| AGENCY | PURPOSE |
|---|---|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |

☐ **CLIENT AGREEMENT** – By my signature, I affirm that I have read, or have had explained to me, the above statements. The telephone number I need for questions or complaints has been left with me, and I do give the authorization for release of information as listed above. Unless otherwise stated, this expires in one year.

_____ _____
Signature of Individual or Authorized Representative Date

_____ _____
Signature of Options Counselor Date

# Provider Authorization/Notification of Change

**PROVIDER AUTHORIZATION/NOTIFICATION OF CHANGE**

☐ **Service Start** ☐ **Service Change** ☐ **Change of Information** ☐ **Service End**

☐ **Hold as of:** _____ ☐ **Resume Services as of:** _____

**I. Individual's Information**

| Name: | DOB: | Id#: | County: |
|---|---|---|---|
| Street Address: | | City/Zip Code: | |
| Phone #: | Emergency Contact: | EC Phone #: | |
| If Title III-E (NFCSP), Name of Care Recipient: | | Care Recipient Id#: | |

**II. Service Authorization**

| Service | Date Service Authorized | Provider Name | Funding Source | Units/ Frequency | Unit Cost | End Date |
|---|---|---|---|---|---|---|
| Homemaker | | | | | | |
| Personal Care | | | | | | |
| Home Delivered Meal | | | | | | |
| Chore | | | | | | |
| In-Home Respite | | | | | | |
| Adult Day Care | | | | | | |
| Other: | | | | | | |

Special Frequency Instructions:

Comments/Considerations:

Options Counselor: _____ Phone: _____

Date Faxed: _____ If Change of Services, Date Individual Notified: _____

**III. Service Provider**

☐ Accepted ☐ Declined Service Start Date: _____ Date Ended: _____

Authorized Provider Signature: _____ Date: _____

**FAX/SCAN REPLY WITH START DATE WITHIN 5 WORKING DAYS TO AAAD**

# Provider Checklist

# PROVIDER CHECKLIST

**Date:** _____ **County:** _____

**Individual's Name:** _____ **Id#:** _____

**If NFCSP, Care Recipient:** _____ **Id#:** _____

## ☐ PERSONAL CARE

***Type of Bath:***
- ☐ Tub Bath
- ☐ Shower
- ☐ Complete bed bath
- ☐ Complete sponge bath
- ☐ Partial sponge bath

***Foot Care:***
- ☐ Foot soak
- ☐ Lotion Feet
- ☐ Other _____

***Hair Care:***
- ☐ Shampoo in shower
- ☐ Shampoo in sink
- ☐ Shampoo in bed
- ☐ Brush hair
- ☐ Shave
- ☐ Other_____

***Mouth Care:***
- ☐ Brush teeth
- ☐ Clean dentures
- ☐ Swab mouth

***Dressing:***
- ☐ Dressing Assistance

***Skin Care:***
- ☐ Lotion massage
- ☐ Other_____

***Nail Care:***
- ☐ Clean nails
- ☐ Other_____

***Ambulation:***
- ☐ Assist to ambulate
- ☐ With assistive device
- ☐ Do not ambulate

***Other Duties:***
- ☐ Assist with eating
- ☐ Assist with toileting

---

## ☐ HOMEMAKER

- ☐ Straighten/Pick up
- ☐ Vacuuming
- ☐ Mop
- ☐ Laundry/Laundromat
- ☐ Dusting
- ☐ Empty trash
- ☐ Prescription pickup
- ☐ Shopping
- ☐ Grocery shopping

***Bedroom:***
- ☐ Change bed linen
- ☐ Straighten bed linen
- ☐ Other_____

***Bathroom:***
- ☐ Clean tub/shower
- ☐ Clean bath basin
- ☐ Clean commode
- ☐ Other_____

***Kitchen:***
- ☐ Clean stove
- ☐ Clean countertop
- ☐ Clean refrigerator
- ☐ Clean dishes
- ☐ Meal preparation
- ☐ Other_____

☐ Special Instructions:

☐ Safety needs identified:

_____ _____

**Signature of Individual or Authorized Representative** **Date**

# Reimbursement Rate of Services

**Reimbursement Rate**

**OPTIONS for Community Living (State-Funded)**
**Older Americans Act – Title III (Federally Funded)**

| Service | Reimbursement Rate |
|---|---|
| Personal Care – OAA Title III | *The lesser of* $20.32 per hr. or usual and customary charges* |
| Personal Care – State Funds | *The lesser of* $20.32 per hr. or usual and customary charges* |
| Homemaker Services – OAA Title III | *The lesser of* $20.32 per hr. or usual and customary charges* |
| Homemaker Services – State Funds | *The lesser of* $20.32 per hr. or usual and customary charges* |
| In-home Respite – OAA Title III | *The lesser of* $16.12 per hr. or usual and customary charges* |
| Hot Home-Delivered Meals – OAA Title III | *The lesser of* $6.93 per meal or usual and customary charges* |
| Hot Home-Delivered Meals – State Funds | *The lesser of* $6.93 per meal or usual and customary charges* |
| Frozen Home-Delivered Meals – OAA Title III | *The lesser of* $5.94 per meal or usual and customary charges* |
| Frozen Home-Delivered Meals – State Funds | *The lesser of* $5.94 per meal or usual and customary charges* |

**For providers who have not established usual and customary charges, the charge should be reasonably related to the provider's cost for providing the service. The same requirements are to be applied in the above noted programs. Thus, only the lesser of the maximum rate as specified above or the usual and customary charges for each service should be billed.*

These are the maximum rates which may **not** be exceeded; a lesser amount should be billed and reimbursed, if the provider's usual and customary charge to persons not participating in these programs is lower. Reimbursement rates for OAA and State-Funded services shall not exceed the TennCare reimbursement rates.

Appendix I

# Social Assistance Management System
# Independent Living Assessment
# (Nutrition Screening Initiative) 2012

# SAMS ILA (NSI) 2012

## 0. Cover Sheet

### 0.A. Client Identification

**1. What is the date of the assessment?**

_____/_____/_____ ___

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

- ☐ 1 - Initial assessment
- ☐ 2 - Reassessment

**3. Where was the client interviewed?**

- ☐ 1 - Home
- ☐ 2 - Hospital
- ☐ 3 - Nursing facility
- ☐ 4 - Other

**4. Describe where the client was interviewed.**

**5. What is the name of the person conducting this assessment?**

**6. What is the name of the agency the assessor works for?**

**7. What is the client's last name?**

**8. What is the client's first name?**

**9. What is the client's middle initial?**

**10. Enter the client's name suffix.**

**11. Enter the client identifier for the client.**

**12. Enter the client's 'also known as' name.**

**13. What is the client's ethnicity?**

- ☐ 1 - Hispanic or Latino
- ☐ 2 - Not Hispanic or Latino
- ☐ 3 - Unknown

**14. What is the client's race?**

- ☐ 1 - American Indian/Native Alaskan
- ☐ 2 - Asian
- ☐ 3 - Black/African American
- ☐ 4 - Native Hawaiian/Other Pacific Islander
- ☐ 5 - Non-Minority (White, non-Hispanic)
- ☐ 6 - Hispanic/Latino - White
- ☐ 7 - Other

**15. Enter the client's telephone number.**

**16. What is the client's Social Security Number?**

_____-_____-_____

**17. What is the client's date of birth?**

____/____/_____

**18. Enter the age of the client in years.**

**19. What document was used to verify the client's age?**

- ☐ Birth certificate
- ☐ Driver's license
- ☐ Employment identification card
- ☐ Military/veteran's identification card
- ☐ Notarized affidavit
- ☐ Passport
- ☐ Self Declaration (Must Complete Age Declaration on Signature Page)
- ☐ Social Security or Medicare card
- ☐ U.S. census records
- ☐ Wedding or divorce decree
- ☐ Other (Answer Next Question if this is chosen)

**20. What other document was used to verify the client's age?**

**21. What is the client's gender?**

- ☐ M - Male
- ☐ F - Female

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

**23. Enter the client's residential city or town.**

**24. Residential zip code.**

**25. What county does the client reside in?**

**26. If different from residential address, enter the client's mailing street address or Post Office box.**

**27. If different from residential address, enter the client's mailing city or town.**

**28. If different from residential address, enter the client's mailing state.**

**29. If different from residential address, enter the client's mailing ZIP code.**

**30. What is the name of the client's caregiver?**

**31. What is the relationship of the primary helper to the client?**

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

## 0.B. Emergency Contact Information

**1. What is the name of the client's primary care physician?**

**2. What is the work phone number for the client's primary care physician?**

**3. Name of Friend or Relative (other than Spouse/Partner) to contact in case of an Emergency.**

**4. Relationship of Friend or Relative (other than Spouse/Partner) to contact in case of an Emergency.**

**5. Address of Friend or Relative (other than Spouse/Partner) to contact in an Emergency.**

**6. Work Telephone Number of Friend or Relative (other than Spouse/Partner) to contact in case of an Emergency.**

**7. Home Telephone Number of Friend or Relative (other than Spouse/Partner) to contact in case of an Emergency.**

**8. Cell Number of Friend or Relative (other than Spouse/Partner) to contact in case of an Emergency.**

**9. What is the name of a second relative or friend of the client?**

**10. What is the work phone number of the second relative or friend of the client?**

**11. What is the home phone number of the second relative or friend of the client?**

**12. What is the e-mail address of a Family Member?**

## 0.C. Directions to Client's Home

**Directions on how to get to the client's home.**

## 1. Intake

### 1.A. Standard Data

**1. Did someone help the client or answer questions for the client?**

- [ ] Y - Yes
- [ ] N - No

**2. What is the name of the person that helped the client during this assessment?**

**3. What is the helper's relationship to the client?**

**4. Was communication/language assistance needed for this assessment?**

- [ ] Y - Yes
- [ ] N - No

**5. Specify the client's primary language.**

- [ ] English
- [ ] Spanish
- [ ] French
- [ ] Italian
- [ ] German
- [ ] Russian
- [ ] Other

**6. What type of communication/language assistance was needed for this assessment?**

### 1.B. Legal Representative

**1. Does the client have a power of attorney?**

- [ ] Y - Yes
- [ ] N - No

**2. What is the name of the client's power of attorney?**

**3. Enter the work phone number of the client's power of attorney.**

**4. Enter the home phone number of the client's power of attorney.**

**5. Does the client have a DPOA for health care?**

- [ ] Y - Yes
- [ ] N - No

**6. What is the name of the client's DPOA for health care?**

**7. Enter the work phone number of the client's DPOA for health care.**

**8. Enter the home phone number of the client's DPOA for health care.**

**9. Does the client have a DPOA for finances?**

- [ ] Y - Yes
- [ ] N - No

**10. What is the name of the client's DPOA for finances?**

**11. Enter the work phone number of the client's DPOA for finances.**

**12. Enter the home phone number of the client's DPOA for finances.**

**13. Does the client have a representative payee?**

- [ ] Y - Yes
- [ ] N - No

**14. What is the name of the client's representative payee?**

**15. Enter the work phone number of the client's representative payee.**

**16. Enter the home phone number of the client's representative payee.**

**17. Does the client have a legal guardian?**

- [ ] Y - Yes
- [ ] N - No

**18. What is the name of the client's guardian?**

**19. Enter the work phone number of the client's guardian.**

**20. Enter the home phone number of the client's guardian.**

**21. Does the client have a living will?**

- [ ] Y - Yes
- [ ] N - No

**22. Name of person holding copy of DPOA/Living Will.**

**23. Telephone number of person holding copy of DPOA/Living Will.**

**24. Address of person holding second copy of DPOA/Living Will.**

**25. If the client does not have a living will, was information provided about advanced directives?**

- [ ] Y - Yes
- [ ] N - No

## 1.C. Assessment Information

**1. Select the client's current marital status.**

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

**2. Indicate the type of residence that the client currently resides in.**

- [ ] A - House/mobile home
- [ ] B - Private apartment
- [ ] C - Private apartment in senior housing
- [ ] D - Residential care home
- [ ] E - Nursing home
- [ ] F - Unavailable
- [ ] Z - Other

**3. Is the client NSIP eligible for home delivered meal reimbursement? (Regardless of whether or not they need meals, if they are over the age of 60 or meet one of the conditions on the next question, you will generally check yes.)**

- [ ] Yes
- [ ] No

**4. For what reason is the client NSIP eligible for home delivered meals?**

- [ ] Disabled individual residing in an elderly housing which serves congregate meals
- [ ] Age 60+ or Tribal Age
- [ ] Spouse of someone who is NSIP eligible

## 1.D. Social Screening

**1. Select the client's current living arrangement.**

- [ ] A - Lives Alone (3)
- [ ] B - With spouse/partner
- [ ] C - Lives with spouse and child
- [ ] D - With child/children
- [ ] F - With others (2)

**2. If b, c, or d is checked: Ask if any of the person(s) that live with you are able to assist with your care? (If No, score 2)**

- [ ] No (2)
- [ ] Yes

**3. What is the name of the client's spouse/partner?**

_____

_____

_____

_____

**4. How many people are there in the client's household?**

- ☐ A - One person
- ☐ B - Two people
- ☐ C - Three people
- ☐ D - Four or more people

**5. Does the client have any children nearby?**

- ☐ Y - Yes
- ☐ N - No (2)

**6. Does the client have contact with family often enough?**

- ☐ Y - Yes
- ☐ N - No (3)

**7. Does the client have contact with friends often enough?**

- ☐ Y - Yes
- ☐ N - No (2)

**8. Is there a friend or relative that could take care of the client for a few days?**

- ☐ Y - Yes
- ☐ N - No (3)

**9. When the client makes a decision about something, how does s/he do it?**

- ☐ A - Independently and alone
- ☐ B - Independently after talking to family/friends (1)
- ☐ C - Follow advice of family/friends (2)
- ☐ D - Dependent (3)
- ☐ E - Information unavailable (Choose only if consumer not able to answer score 3)

**10. Is the client currently employed?**

- ☐ Yes
- ☐ No
- ☐ Full time

**11. Is the client participating in any of the following services or programs?**

- ☐ Statewide Medicaid Waiver/CHOICES
- ☐ Homemaker program
- ☐ Home Health Aide
- ☐ Nursing
- ☐ Speech therapy
- ☐ Occupational therapy
- ☐ Physical therapy
- ☐ Home delivered meals
- ☐ PERS - Personal Emergency Response System
- ☐ Senior companion
- ☐ Weatherization
- ☐ Congregate meals
- ☐ Adult day services
- ☐ Food stamps
- ☐ Fuel Assistance
- ☐ Telephone lifeline
- ☐ Medicaid
- ☐ SSI
- ☐ QMB/SLMB
- ☐ QI-1
- ☐ Personal care
- ☐ Respite care
- ☐ Minor Home Repairs
- ☐ Assistive Devices
- ☐ Private Duty
- ☐ 504 USDA program
- ☐ Extra help for Part D Medicare
- ☐ Other

**12. Does the client want to apply for any of the following services or programs?**

- ☐ B - Medicaid waiver
- ☐ C - Homemaker program
- ☐ I - Home delivered meals
- ☐ J - Emergency lifeline
- ☐ L - Weatherization
- ☐ M - Congregate meals
- ☐ O - Adult day services
- ☐ R - Fuel Assistance
- ☐ T - Medicaid
- ☐ U - SSI
- ☐ 1 - Personal care
- ☐ 2 - Respite care
- ☐ 3 - Minor Home Modifications
- ☐ 4 - Assistive Devices
- ☐ 5 - Private Duty
- ☐ O - Other

**Enter Social Score**

## 1.E. Health Screening

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

- ☐ A - Excellent
- ☐ B - Good
- ☐ C - Fair (2)
- ☐ D - Poor (3)
- ☐ E - Information unavailable

**2. In the past year, how many times has the client stayed overnight in a hospital?**

- ☐ 1 - Not at all (0)
- ☐ 2 - Once (1)
- ☐ 3 - 2 or 3 times (2)
- ☐ 4 - More than 3 times (3)

**3. In the past 6 months has the client stayed in a nursing home, residential care home, or other institution?**

- ☐ Y - Yes (2)
- ☐ N - No

**4. Indicate which of the following conditions/diagnoses the client currently has.**

- [ ] Addiction
- [ ] Alcoholism/substance abuse
- [ ] Allergies
- [ ] Alzheimer's disease
- [ ] Anemia
- [ ] Ankle/leg swelling
- [ ] Anxiety disorder
- [ ] Any psychiatric diagnosis
- [ ] Aphasia
- [ ] Arteriosclerosis heart disease (ASHD)
- [ ] Arthritis/rheumatic disease/gout
- [ ] Asthma
- [ ] Blood-related problems
- [ ] Breathing disorders
- [ ] Bruises
- [ ] Cancer
- [ ] Cardiac dysrhythmias
- [ ] Cataract
- [ ] Cerebral palsy
- [ ] Chronic pain
- [ ] Chronic weakness/fatigue
- [ ] Congestive heart failure
- [ ] Contractures
- [ ] Coronary artery disease
- [ ] Decubitus
- [ ] Deep vein thrombosis
- [ ] Depression
- [ ] Developmental disability
- [ ] Diabetes
- [ ] Diabetic retinopathy
- [ ] Dialysis
- [ ] Digestive problems
- [ ] Drug resistance (MRSA/VRE)
- [ ] Edema
- [ ] Emphysema/COPD/asthma
- [ ] Expressive communication
- [ ] Fibromyalgia
- [ ] Frailty
- [ ] Frequent falls
- [ ] Gastritis or related condition
- [ ] Glaucoma
- [ ] Hearing impairment
- [ ] Heart problems
- [ ] Hemiplegia/Hemiparesis
- [ ] High cholesterol
- [ ] Hip fracture
- [ ] HIV
- [ ] Hypertension
- [ ] Hyperthyroidism
- [ ] Hypotension
- [ ] Hypothyroidism
- [ ] Immune system disorders
- [ ] Incontinence, bladder
- [ ] Incontinence, bowel
- [ ] Incontinent
- [ ] Liver disease
- [ ] Macular degeneration
- [ ] Manic depression (bipolar disease)
- [ ] Memory Loss
- [ ] Missing limb (e.g., amputation)
- [ ] Multiple sclerosis
- [ ] Muscle or bone problems
- [ ] Nausea/vertigo
- [ ] Neurological condition
- [ ] Non-Alzheimer's dementia
- [ ] Osteoporosis
- [ ] Other cardiovascular disease
- [ ] Other eye condition
- [ ] Other fracture (except hip/spine)
- [ ] Other neurological
- [ ] Other significant illness
- [ ] Paralysis
- [ ] Paraplegia
- [ ] Parkinson's disease
- [ ] Pathological bone fracture
- [ ] Peripheral vascular disease
- [ ] Pneumonia
- [ ] Post Traumatic Stress Syndrome
- [ ] Quadriplegia
- [ ] Receptive communication
- [ ] Renal failure
- [ ] Respiratory disease
- [ ] Schizophrenia
- [ ] Seizure disorder
- [ ] Speech impairment
- [ ] Stroke
- [ ] TB
- [ ] Thyroid disease
- [ ] Transient ischemic attack (TIA)
- [ ] Traumatic brain injury
- [ ] Tremors
- [ ] Urinary problems
- [ ] Urinary tract infection
- [ ] Vision problems
- [ ] None of the Above

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

**6. Is the client limited in what s/he can do because of this health problem?**

- ☐ Y - Yes (3)
- ☐ N - No

**7. How often does bad health, sickness, pain, or disability stop the client from doing things s/he would like to do?**

- ☐ A - Never
- ☐ B - Sometimes (1)
- ☐ C - Often (2)
- ☐ D - Always (3)

**8. Has the client fallen in the past three months?**

- ☐ Y - Yes (3)
- ☐ N - No

**9. In a typical week, during the last 30 days, how often did the client go outside of their residence (no matter for how short a period of time)?**

- ☐ A - Two or more days a week
- ☐ B - One day a week or less (2)

**10. Does the client use a walker/cane to get around?**

- ☐ Y - Yes (3)
- ☐ N - No

**11. Does the client use a wheelchair to get around or is bedbound?**

- ☐ Y - Yes (3)
- ☐ N - No

**12. Does the client have problems with hearing that are NOT corrected with aids/devices?**

- ☐ Y - Yes (1)
- ☐ N - No

**13. If the client has hearing aids/devices, are they in working order?**

- ☐ Y - Yes
- ☐ N - No

**14. Does the client have problems with vision that are not corrected with aids/devices?**

- ☐ Y - Yes (1)
- ☐ N - No

**15. If the consumer uses vision aids/devices, are they in working order?**

- ☐ Y - Yes
- ☐ N - No

**16. Does the client have problems with speech that are not corrected with aids/devices?**

- ☐ Y - Yes (1)
- ☐ N - No

**17. Describe any aids/devices used by the client to correct speech problems.**

**18. If the consumer uses speech aids/devices are they in working order?**

- ☐ Y - Yes
- ☐ N - No

**19. Does the client often feel sad or blue?**

- ☐ Y - Yes (3)
- ☐ N - No

**20. Expressions of lack of pleasure in life (e.g. I do not enjoy anything anymore)**

- ☐ Content
- ☐ Happy
- ☐ Hopeless
- ☐ Lonely

**21. Has the consumer had Suicidal thoughts?**

- ☐ Yes
- ☐ No

**22. How many prescription medications does the client take?**

☐

**23. Is the number of Medications the client is taking 3 or more?**

- ☐ Y - Yes (1)
- ☐ N - No

**24. Does the client have a history of alcohol or drug abuse or history of mixing medications/alcohol?**

- ☐ Yes
- ☐ No

**25. Is there evidence that the client has problems with substance abuse?**

- ☐ Yes
- ☐ No

**26. Describe any history of alcohol or drug abuse as it relates to the question above.**

**27. What was the client's response when asked, 'What year is it?'**

- ☐ A - Correct answer
- ☐ B - Incorrect answer

**28. What was the client's response when asked, 'What month is it?'**

- ☐ A - Correct answer
- ☐ B - Incorrect answer

**29. What was the client's response when asked, 'Where are we now?'**

- ☐ A - Correct answer
- ☐ B - Incorrect answer

**30. Indicate worker's judgment of client's overall mental clarity/cognitive functions.**

- ☐ 1 - Good
- ☐ 2 - Fair (2)
- ☐ 3 - Poor (3)

**31. In the past six months, has the client lost more than 10 pounds without trying?**

- ☐ Yes (2)
- ☐ No

**Enter Health Screening Score.**

## 1.F. Nutrition Screening

**1. Has the client made any changes in lifelong eating habits because of health problems?**

- ☐ Y - Yes (2)
- ☐ N - No (0)

**2. Does the client eat fewer than 2 meals per day?**

- ☐ Y - Yes (3)
- ☐ N - No (0)

**3. Does the client eat fewer than five (5) servings (1/2 cup each) of fruits or vegetables every day?**

- ☐ Y - Yes (1)
- ☐ N - No (0)

**4. Does the client eat fewer than two servings of dairy products (such as milk, yogurt, or cheese) every day?**

- ☐ Y - Yes (1)
- ☐ N - No (0)

**5. Does the client have 3 or more drinks of beer, liquor or wine almost every day?**

- ☐ Y - Yes (2)
- ☐ N - No (0)

**6. Does the client have biting, chewing or swallowing problems that make it difficult to eat?**

- ☐ Y - Yes (2)
- ☐ N - No (0)

**7. Does the client sometimes not have enough money to buy food?**

- ☐ Y - Yes (4)
- ☐ N - No (0)

**8. Does the client eat alone most of the time?**

- ☐ Y - Yes (1)
- ☐ N - No (0)

**9. Does the client take 3 or more different prescribed or over-the-counter drugs per day?**

- ☐ Y - Yes (1)
- ☐ N - No (0)

**10. Without wanting to, has the client lost or gained 10 pounds in the past 6 months?**

- ☐ Y - Yes (2)
- ☐ N - No (0)

**11. Is the client not always physically able to shop, cook and/or feed themselves (or able to get someone to do it for them)?**

- ☐ Y - Yes (2)
- ☐ N - No (0)

**Total score of Nutritional Risk Questions.**

**What is the client's nutritional risk score rating?**

- ☐ High risk (6 or more)
- ☐ Moderate risk (3-5)
- ☐ No risk (0-2)

## 2. Functional Assessment

### 2.A. Activities of Daily Living (ADL)

**1. During the past 7 days, and considering all episodes, 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
- [ ] 1 - Supervision (1)
- [ ] 2 - Requires assistance sometimes (1)
- [ ] 3 - Mostly dependent (1)
- [ ] 4 - Totally dependent (1)
- [ ] 5 - Activity does not occur (1)

**Is the help the client receives bathing enough?**

- [ ] Y - Yes
- [ ] N - No

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

- [ ] 0 - Independent
- [ ] 1 - Supervision (1)
- [ ] 2 - Limited Assistance (1)
- [ ] 3 - Extensive Assistance (1)
- [ ] 4 - Total Dependence (1)
- [ ] 5 - Activity did not occur (1)

**Is the help the client receives dressing enough?**

- [ ] Y - Yes
- [ ] N - No

**3. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform TOILET USE?**

- [ ] 0 - Independent
- [ ] 1 - Supervision (1)
- [ ] 2 - Sometimes dependent (1)
- [ ] 3 - Mostly dependent (1)
- [ ] 4 - Totally dependent (1)
- [ ] 5 - Activity does not occur (1)

**Is the help the client receives using the toilet enough?**

- [ ] Y - Yes
- [ ] N - No

**4. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform getting out of bed/chairs/transferring?**

- [ ] 0 - Independent
- [ ] 1 - Supervision (1)
- [ ] 2 - Minimal assistance required (1)
- [ ] 3 - Mostly dependent (1)
- [ ] 4 - Totally dependent (1)
- [ ] 5 - Activity does not occur (1)

**Is the help the client receives getting in and out of bed/chairs enough?**

- [ ] Y - Yes
- [ ] N - No

**5. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform EATING?**

- [ ] 0 - Independent
- [ ] 1 - Supervision (1)
- [ ] 2 - Sometimes dependent (1)
- [ ] 3 - Mostly dependent (1)
- [ ] 4 - Totally dependent (1)

**Is the help the client receives eating enough?**

- [ ] Y - Yes
- [ ] N - No

**6. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform WALKING IN HOME?**

- [ ] 0 - Independent
- [ ] 1 - Supervision (1)
- [ ] 2 - Limited Assistance (1)
- [ ] 3 - Extensive Assistance (1)
- [ ] 4 - Total Dependence (1)
- [ ] 5 - Activity did not occur (1)

**Is the help the client receives getting around the home enough?**

- [ ] Y - Yes
- [ ] N - No

**How many ADL impairments does the client have (Count or Total)?**

[ ]

### 2.B. Instrumental Activities of Daily Living (IADL)

**1. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform MEAL PREPARATION?**

- [ ] 0 - Independent
- [ ] 1 - Sometimes dependent (1)
- [ ] 2 - Mostly dependent (1)
- [ ] 3 - Totally dependent (1)
- [ ] 4 - Activity does not occur (1)

**Is the help the client receives preparing meals enough?**

- [ ] Y - Yes
- [ ] N - No

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

- [ ] 0 - Independent
- [ ] 1 - Somewhat dependent (1)
- [ ] 2 - Mostly dependent (1)
- [ ] 3 - Totally dependent (1)
- [ ] 4 - Activity does not occur (1)

**Is the help the client receives shopping enough?**

- [ ] Y - Yes
- [ ] N - No

**3. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform MANAGING MEDICATIONS?**

- [ ] 0 - Independent
- [ ] 1 - Needs reminders (1)
- [ ] 2 - Somewhat dependent (1)
- [ ] 3 - Totally dependent (1)
- [ ] 4 - Activity does not occur (1)

**Is the help the client receives taking medication enough?**

- [ ] Y - Yes
- [ ] N - No

**4. Specify the client's ability to MANAGE MONEY.**

- [ ] 0 - Completely independent
- [ ] 1 - Needs assistance sometimes (1)
- [ ] 2 - Needs assistance most of the time (1)
- [ ] 3 - Completely dependent (1)
- [ ] 4 - Activity does not occur (1)

**Is the help the client receives managing money enough?**

- [ ] Y - Yes
- [ ] N - No

**5. Rank the client's ability to use the TELEPHONE.**

- [ ] 0 - Independent
- [ ] 1 - Able to perform but needs verbal assistance (1)
- [ ] 2 - Can perform with some human help (1)
- [ ] 3 - Can perform with a lot of human help (1)
- [ ] 4 - Cannot perform function at all without human help (1)

**Is the help the client receives using the telephone enough?**

- [ ] Y - Yes
- [ ] N - No

**6. Specify the client's ability to perform HEAVY HOUSEWORK CHORES.**

- [ ] 0 - Independent
- [ ] 1 - Needs assistance sometimes (1)
- [ ] 2 - Needs assistance most of the time (1)
- [ ] 3 - Unable to perform tasks (1)
- [ ] 4 - Activity does not occur (1)

**Is the help the client receives performing heavy household chores enough?**

- [ ] Y - Yes
- [ ] N - No

**7. Specify the client's ability to perform LIGHT HOUSEKEEPING.**

- [ ] 0 - Independent
- [ ] 1 - Needs assistance sometimes (1)
- [ ] 2 - Needs assistance most of the time (1)
- [ ] 3 - Unable to perform tasks (1)
- [ ] 4 - Activity does not occur (1)

**Is the help the client receives doing housework enough?**

- [ ] Y - Yes
- [ ] N - No

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

- [ ] 0 - Independent
- [ ] 1 - Somewhat dependent (1)
- [ ] 2 - Mostly dependent (1)
- [ ] 3 - Totally dependent (1)

**Is the help the client receives using transportation enough?**

- [ ] Y - Yes
- [ ] N - No

**9. Does the client have any of the following devices or equipment used to help perform the above ADL/IADL?**

- [ ] Artificial limb
- [ ] Bath stool
- [ ] Bedside commode
- [ ] Cane
- [ ] Dentures
- [ ] Extended shower head/Hand held shower
- [ ] Eyeglasses
- [ ] Grab bars
- [ ] Hearing aid
- [ ] Hospital bed
- [ ] Lift chair
- [ ] Nebulizer
- [ ] Oxygen
- [ ] Raised toilet seat
- [ ] Ramp
- [ ] Walker
- [ ] Wheelchair
- [ ] Other

**10. Any of Other devices or equipment not listed, If other.**

_____

_____

_____

_____

**How many IADL impairments does the client have (Count or Total)?**

[ ]

**Total Score (Social + Health+ADL/IADL)**

_____

_____

_____

_____

## 3. Financial Resources

### 3.A.i. Client Resources

1. **Specify the client's monthly social security income.**

$

2. **Specify the client's monthly SSI income.**

$

3. **Specify the client's monthly retirement/pension income.**

$

4. **Specify the client's monthly interest income.**

$

5. **Specify the client's monthly VA benefits income.**

$

6. **Specify the client's monthly wage/salary/earnings income.**

$

7. **Specify the client's other monthly income.**

$

### 3.A.ii. Spouse Resources

1. **Specify the monthly social security income of the client's spouse.**

$

2. **Specify the monthly SSI income of the client's spouse.**

$

3. **Specify the monthly retirement/pension income of the client's spouse.**

$

4. **Specify the monthly interest income of the client's spouse.**

$

5. **Specify the monthly VA benefits income of the client's spouse.**

$

6. **Specify the monthly wage/salary/earnings income of the client's spouse.**

$

7. **Specify other monthly income of the client's spouse.**

$

### 3.A.iii. Total Resources

1. **Specify the client's MONTHLY income.**

$

2. **What is the client's monthly income?**

- ☐ $931 or less
- ☐ $1,261 or less
- ☐ $1,591 or less
- ☐ $1,921 or less
- ☐ $2,251 or less

3. **How many people in the household does the client support on his/her income?**

4. **What is the client's TOTAL MONTHLY HOUSEHOLD income?**

$

5. **Based on the Range, Is the CLIENT'S income level below the national poverty level?**

- ☐ Yes
- ☐ No

### 3.B. Monthly Housing Costs

1. **Specify the client's monthly rent.**

$

2. **Specify the client's monthly mortgage.**

$

3. **Specify the client's monthly property tax.**

$

4. **Specify the client's monthly heat bill.**

$

5. **Specify the client's monthly utilities bill.**

$

6. **Specify the client's monthly house insurance cost.**

$

7. **Specify the client's monthly telephone bill.**

$

8. **Specify the client's other monthly costs.**

$

9. **What is the consumer's estimated total medical monthly expenses(e.g. health insurance premiums, hospital and doctor bills, prescription costs)?**

$

10. **Enter the client's total monthly housing expenses.**

$

## 3.C. Savings/Assets

1. **What is the client's savings account/CD/investments balance?**

$

2. **What is the client's checking account balance?**

$

## 3.D. Health Insurance

1. **Enter the client's Medicare number.**

2. **Does the client have Medicare A health insurance?**

Yes
No

3. **Does the client have Medicare B health insurance?**

Y - Yes
N - No

4. **Does the client have Medigap health insurance?**

Y - Yes
N - No

**What is the name of the client's Medigap health insurer?**

5. **Does the client have Medicare D health insurance?**

Y - Yes
N - No

**What is the name of the client's Medicare D company/plan?**

6. **Does the client have LTC health insurance?**

Y - Yes
N - No

**What is the name of the client's LTC health insurer?**

7. **Does the client have other health insurance?**

Y - Yes
N - No

**What is the name of the client's other health insurer?**

## 3 Comments

**Comment on the client's current financial situation.**

## 4. Health Assessment

### 4.A. Current Health Status

**1. Describe the client's allergies, if any.**

**2. Describe the client's special diet(s).**

**3. Does the client smoke or chew tobacco regularly?**

- ☐ Deferred
- ☐ Don't know
- ☐ No
- ☐ Yes

### 4.B. Medication Use

**1. List all prescribed and non prescribed medications taken by the client in the last 7 days.**

**Name and Dose:** Record the name of the medication and dose ordered.

**Unit type:**

| | | |
|---|---|---|
| gtts (Drops) | mEq (Milli-equivalent) | Puffs |
| gm (Gram) | mg (Milligram) | % (Percentage) |
| L (Liters) | ml (Milliliter) | Units |
| mcg (Microgram) | oz (Ounce) | OTH (Other) |

**Form:** Code the route of administration using the following list:

| | |
|---|---|
| 1 = by mounth (PO) | 7 = topical |
| 2 = sub lingual (SL) | 8 = inhalation |
| 3 = intramuscular (IM) | 9 = enteral tube |
| 4 = intravenous (IV) | 10 = other |
| 5 = subcutaneous (SQ) | 11 = eye drop |
| 6 = rectal (R) | 12 = transdermal |

**Frequency:** Code the number of times per period the med is administered using the following list:

| | |
|---|---|
| PR = (PRN) as necessary | OO = every other day |
| 1H = (QH) every hour | 1W = (Q week) once each week |
| 2H = (Q2H) every 2 hours | 2W = 2 times every week |
| 3H = (Q3H) every 3 hours | 3W = 3 times every week |
| 4H = (Q4H) every 4 hours | 4W = 4 times each week |
| 6H = (Q6H) every 6 hours | 5W = 5 times each week |
| 8H = (Q8H) every eight hours | 6W = 6 times each week |
| 1D = (QD or HS) once daily | 1M = (Q month) once/mo. |
| 2D = (BID) two times daily *(includes every 12 hours)* | 2M = twice every month |
| | C = Continuous |
| 3D = (TID) 3 times daily | O = Other |
| 4D = (QID) four times daily | |
| 5D = 5 times daily | |

| Name | Dose | Form | Freq. | PRN | # Taken | Drug Code | Comments |
|---|---|---|---|---|---|---|---|

**1. Continued**

**2. How does the client remember to take his/her medications?**

## 5. Mental Health/Behavior/Cognition

### 5.A. Mental Health Services

**1. In the past year, has the client received (or is the client currently receiving) mental health treatment or counseling?**

- [ ] Y - Yes
- [ ] N - No

**2. What kinds of services has the client received, or what kinds of services is the client receiving now?**

_____

_____

_____

_____

### 5.B. Behavior

**1. Does spouse, partner, caregiver or other person, including this assessor, suggest that the client has memory or emotional problems?**

- [ ] Y - Yes
- [ ] N - No

**2. How often does the client get lost or wander?**

- [ ] 1 - Less than daily
- [ ] 2 - Daily
- [ ] 3 - Multiple times per day
- [ ] 4 - Never

**3. How often is the client physically abusive to him/herself?**

- [ ] 1 - Less than daily
- [ ] 2 - Daily
- [ ] 3 - Multiple times per day
- [ ] 4 - Never

**4. How often is the client physically abusive to others?**

- [ ] 1 - Less than daily
- [ ] 2 - Daily
- [ ] 3 - Multiple times per day
- [ ] 4 - Never

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

- [ ] 1 - Less than daily
- [ ] 2 - Daily
- [ ] 3 - Multiple times per day
- [ ] 4 - Never

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

- [ ] 1 - Less than daily
- [ ] 2 - Daily
- [ ] 3 - Multiple times per day
- [ ] 4 - Never

**7. How often does the client experience hallucinations/delusions?**

- [ ] 1 - Less than daily
- [ ] 2 - Daily
- [ ] 3 - Multiple times per day
- [ ] 4 - Never

### 5.C. Cognition

**1. How often does the client have problems with his/her short term memory?**

- [ ] 1 - Less than daily
- [ ] 2 - Daily
- [ ] 3 - Multiple times per day
- [ ] 4 - Never

**2. How often does the client have problems making him/herself understood?**

- [ ] 1 - Less than daily
- [ ] 2 - Daily
- [ ] 3 - Multiple times per day
- [ ] 4 - Never

**3. How often does the client have problems with long term memory?**

- [ ] 1 - Less than daily
- [ ] 2 - Daily
- [ ] 3 - Multiple times per day
- [ ] 4 - Never

**4. How often does the client have problems understanding others?**

- [ ] 1 - Less than daily
- [ ] 2 - Daily
- [ ] 3 - Multiple times per day
- [ ] 4 - Never

**5. How often does the client have problems with decision making?**

- [ ] 1 - Less than daily
- [ ] 2 - Daily
- [ ] 3 - Multiple times per day
- [ ] 4 - Never

## 6. Home Environment

### 6.A. Environmental Checklist

**1. Does the client have problems with dangerous stairs or floors in his/her home?**

- ☐ Y - Yes
- ☐ N - No

**2. Is it difficult for the client to get to the entrance of his/her home?**

- ☐ Y - Yes
- ☐ N - No

**3. Is it difficult for the client to get to the bathroom or bedroom in his/her home?**

- ☐ Y - Yes
- ☐ N - No

**4. Does the client have problems with the major appliances or toilet in his/her home?**

- ☐ Y - Yes
- ☐ N - No

**5. Does the client have problems with the heating or cooling in his/her home?**

- ☐ Y - Yes
- ☐ N - No

**6. Does the client have problems getting water or hot water in his/her home?**

- ☐ Y - Yes
- ☐ N - No

**7. Does the client have difficulties keeping his/her home free from odor or pests?**

- ☐ Y - Yes
- ☐ N - No

**8. Does the client need a smoke alarm in his/her home?**

- ☐ Y - Yes
- ☐ N - No

**9. Does the client have problems with electrical hazards in his/her home?**

- ☐ Y - Yes
- ☐ N - No

**10. Does the client have problems with poor lighting in his/her home?**

- ☐ Y - Yes
- ☐ N - No

**11. Does the client have problems with an unsafe stove in his/her home?**

- ☐ Y - Yes
- ☐ N - No

**12. Does the client have problems with loose slippery rugs in his/her home?**

- ☐ Y - Yes
- ☐ N - No

**13. Does the client have problems with inadequate locks on the doors and/or windows in his/her home?**

- ☐ Y - Yes
- ☐ N - No

**14. Does the client have problems keeping his/her home clean and free of clutter?**

- ☐ Y - Yes
- ☐ N - No

**15. Does the client have any other environmental problems in his/her home?**

- ☐ Y - Yes
- ☐ N - No

**16. Describe any other environmental problems.**

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

- ☐ Y - Yes
- ☐ N - No

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

- ☐ Y - Yes
- ☐ N - No

**19. Comment on the client's home environment in general and establish a safety evacuation plan if necessary.**

Title : _____ Date _____

Title : _____ Date _____