

Florida Department of Elder Affairs  
701B Comprehensive Assessment  
Rule: 58-A-1.010, F.A.C.

Provider ID: \_\_\_\_\_

Provider  
Assessor/CM ID: \_\_\_\_\_

Assessor/Case  
Manager (CM) Name: \_\_\_\_\_

Signature: \_\_\_\_\_

**A. DEMOGRAPHIC SECTION**

1. **ASSESSOR/CM: What is the purpose of this assessment?**

Initial    Annual    Health    Living situation    Caregiver    Environment    Income

2. Social Security number: \_\_\_\_\_

3. Name: a. First: \_\_\_\_\_ b. Middle initial: \_\_\_\_\_

c. Last: \_\_\_\_\_

4. Medicaid number: \_\_\_\_\_

5. Phone number: \_\_\_\_\_

6. Date of birth (mm/dd/yyyy): \_\_\_\_\_

7. Sex:                                       Male                                       Female

8. Race (Mark all that apply):    White                                       Black/African American                                       Asian  
    American Indian/Alaska Native    Native Hawaiian/Pacific Islander    Other

9. Ethnicity:                                       Hispanic/Latino                                       Other

10. Primary language:                                       English                                       Spanish                                       Other: \_\_\_\_\_

11. Does client have limited ability reading, writing, speaking, or understanding English?    No    Yes

12. Marital status:    Married    Partnered    Single    Separated    Divorced    Widowed

13. **ASSESSOR/CM: Current Physical Location Address** (If type is a facility, enter facility name.)

a. Street: \_\_\_\_\_

b. City: \_\_\_\_\_ c. ZIP code: \_\_\_\_\_

d. Type:                                       Private residence                                       Assisted living facility (ALF)                                       Nursing facility  
    Hospital                                       Adult day care                                       Other

e. Name: \_\_\_\_\_

14. Home Address (If different from current physical location)

a. Street: \_\_\_\_\_

b. City: \_\_\_\_\_ c. ZIP code: \_\_\_\_\_

15. Is client's home address public housing?    No    Yes

16. Mailing Address (If different from current physical location)

a. Street: \_\_\_\_\_ b. City: \_\_\_\_\_

c. State: \_\_\_\_\_ d. ZIP code: \_\_\_\_\_

**A. DEMOGRAPHIC SECTION, CONTINUED**

17. **ASSESSOR/CM: Assessment date:** (mm/dd/yyyy) \_\_\_\_\_

18. **ASSESSOR/CM: Assessment site:**  
 Home    ALF    Nursing facility    Hospital    Adult day care    Other

19. **ASSESSOR/CM: Referral date:** (mm/dd/yyyy) \_\_\_\_\_

20. **ASSESSOR/CM: Referral source:**    Self/Family    Nursing facility    Case management agency  
 CARES    Aging out    Hospital    Department of Children and Families    Other  
 APS: Select level of APS risk:    High    Intermediate    Low

21. **ASSESSOR/CM: Transitioning out of a nursing facility?**    No    Yes

22. **ASSESSOR/CM: Imminent risk of nursing home placement?**    No    Yes

23. Do you need outside assistance to evacuate?    No    Yes

24. Are you enrolled on a special needs registry?    No    Yes

25. Is there a primary caregiver?    No    Yes

26. Living situation:    With primary caregiver    With other caregiver    With other    Alone

27. Individual monthly income:   \$ \_\_\_\_\_    Refused

28. Couple monthly income:   \$ \_\_\_\_\_    Refused    N/A

29. Estimated total individual assets:   \$ \_\_\_\_\_  
 \$0 to \$2,000    \$2,001 to \$5,000    \$5,001 or more    Refused

30. Estimated total couple assets:   \$ \_\_\_\_\_  
 \$0 to \$3,000    \$3,001 to \$6,000    \$6,001 or more    Refused    N/A

31. Are you receiving S/NAP (food stamps)?    No    Yes

32. Do you need other assistance for food?    No    Yes

33. **ASSESSOR/CM: Is someone besides the client providing answers to questions?**    No (Skip to 34)    Yes  
a. Name: \_\_\_\_\_ b. Relationship: \_\_\_\_\_

34. Besides your own children, how many children under age 19 do you live with and provide care for? (if zero, skip to 35) # \_\_\_\_\_  
a. How many are grandchildren? # \_\_\_\_\_ Name(s): \_\_\_\_\_  
b. How many are other related children? # \_\_\_\_\_ Name(s): \_\_\_\_\_  
c. How many are other non-related children? # \_\_\_\_\_ Name(s): \_\_\_\_\_

35. How many disabled adults age 19 to 59 do you live with and provide care for? (if zero, skip to 36) # \_\_\_\_\_  
a. How many are grandchildren? # \_\_\_\_\_ Name(s): \_\_\_\_\_  
b. How many are other relatives? # \_\_\_\_\_ Name(s): \_\_\_\_\_  
c. How many are other non-relatives? # \_\_\_\_\_ Name(s): \_\_\_\_\_

**Notes & Summary:**

**B. MEMORY SECTION**

36. Has a doctor or other health care professional told you that you suffer from memory loss, cognitive impairment, any type of dementia, or Alzheimer's disease?  No  Yes
37. **ASSESSOR/CM: If the client is not answering questions, skip to Question 47 and check:**
38. "I am going to say three words for you to remember. Please repeat the words after I have said them. The words are: sock (something to wear), blue (a color), and bed (a piece of furniture). Now you tell me the three words." **ASSESSOR/CM: Select the number of words correctly repeated after the first attempt:**  
 Sock  Blue  Bed Total number of correct words:  None  One  Two  Three  
 "Thank you. I will ask you to repeat these to me again later."
39. Please tell me what year it is:  Correct  Missed by one year  Missed by two to five years  
 Missed by five or more years  No answer
40. Please tell me what month it is:  Correct  Missed by one month  Missed by two to five months  
 Missed by five or more months  No answer
41. Please tell me what day (of the week) it is:  Correct  Incorrect  No answer
42. "Let's go back to an earlier question. What were those words I asked you to repeat back to me?"  
 Sock  Blue  Bed
43. **ASSESSOR/CM: Number of words correctly recalled without prompting:**  None  One  Two  Three
44. Have any friends or family members expressed concern about your memory?  No  Yes
45. Have you become concerned about your memory or had problems remembering important things?  No (Skip to 47)  Yes
46. How often do you have problems remembering things?  
 Always  Often  Sometimes  Rarely  Don't know
47. **ASSESSOR/CM: In your opinion, are cognitive problems present?**  No  Yes  Don't know

**Notes & Summary:**

**C. GENERAL HEALTH, SENSORY & COMMUNICATION SECTION**

48. How would you rate your overall health at this time?  Excellent  Very Good  Good  Fair  Poor

49. Compared to a year ago, how would you rate your health?  
 Much better  Better  About the same  Worse  Much worse

50. How often do you change or limit your activities out of fear of falling?  
 Never  Occasionally  Often  All of the time

51. How many times have you fallen in the last six months? # \_\_\_\_\_

52. How often are there things you want to do but cannot because of physical problems?  
 Never  Occasionally  Often  All of the time

53. When you need medical care, how often do you get it?  
 Always  Most of the time  Rarely  Only in an emergency  Never

54. When you need transportation to medical care, how often do you get it?  
 Always  Most of the time  Rarely  Only in an emergency  Never

55. Do you drive a car or other motor vehicle?  No  Yes

56. How often do finances/insurance allow you to obtain health care and medications when you need them?  
 Always  Most of the time  Rarely  Only in an emergency  Never

57. Have you visited the emergency room (ER) or been admitted to the hospital within the last year?  
 No  Yes: How many times? ER# \_\_\_\_\_ Hospital # \_\_\_\_\_

58. In the last year were you in a nursing or rehabilitation facility?  No  Yes

59. Are you usually able to climb two or three stair steps?  No  Yes  Don't know

60. **ASSESSOR/CM: Are there any stairs within the dwelling or leading into/out of the dwelling?**  No  Yes

61. Are you usually able to carry a full glass of water across a room without spilling it?  No  Yes  Don't know

62. Has a doctor told you that you currently have vision problems?  No  Yes  Blind (If blind, skip to 63)

a. Have you had an eye exam in the past year?  No  Yes

b. Do you bump into objects (people, doorways) because you don't see them?  No  Yes

c. Is your vision getting worse than it was last year?  No  In one eye  Slightly worse  Much worse

63. Has a doctor told you that you currently have hearing problems?  No  Yes  Deaf (If deaf, skip to 64)

a. Have you had a hearing exam in the past year?  No  Yes

b. Can you understand words clearly over the telephone?  No  Yes

c. Is your hearing worse than it was last year?  No  In one ear  Slightly worse  Much worse

64. **ASSESSOR/CM: Does client rely on writing, gestures, or signs to communicate?**  No  Yes

65. **ASSESSOR/CM: Are the client's words formed properly, not slurred or clipped?**  No  Yes

66. **ASSESSOR/CM: Are any sensory aids or assistive devices currently used?**  No  Yes  
 If yes, please list the type(s) used: \_\_\_\_\_

67. **ASSESSOR/CM: Is there an unmet need for a sensory aid or assistive device?**  No  Yes  
 If yes, please list the type(s) needed: \_\_\_\_\_

**D. ACTIVITIES OF DAILY LIVING SECTION**

68. How much assistance do you need with the following tasks?

Task	No assistance needed	Uses assistive device	Needs supervision or prompt	Needs assistance (but not total help)	Needs total assistance (cannot do at all)
a. Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Using the bathroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Walking/Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

69. **ASSESSOR/CM: Is there an unmet need for an ADL assistive device?**  No  Yes

**If yes, type(s) needed:** \_\_\_\_\_

70. How much assistance do you have with the following tasks?

Task	No assistance needed	Always has assistance	Has assistance most of the time	Rarely has assistance	Never has assistance
a. Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Using the bathroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Walking/Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Notes & Summary:**

**E. INSTRUMENTAL ACTIVITIES OF DAILY LIVING SECTION**

71. How much assistance do you need with the following tasks?

Task	No assistance needed	Uses assistive device	Needs supervision or prompt	Needs assistance (but not total help)	Needs total assistance (cannot do at all)
a. Heavy chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Light housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Using the telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Managing money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Preparing meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Managing medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Using transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

72. **ASSESSOR/CM: Is there an unmet need for an IADL assistive device?**  No  Yes

**If yes, type(s) needed:** \_\_\_\_\_

73. How much assistance do you have with the following tasks?

Task	No assistance needed	Always has assistance	Has assistance most of the time	Rarely has assistance	Never has assistance
a. Heavy chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Light housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Using the telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Managing money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Preparing meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Managing medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Using transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Notes & Summary:**

**F. HEALTH CONDITIONS & THERAPIES SECTION**

74. Have you been told by a physician that you have any of the following health conditions?  
**ASSESSOR/CM: Indicate whether a problem occurred in the past by marking the first box and when a problem is current by marking the second box. Mark all that apply.**

Past	Current	Health Conditions
<input type="checkbox"/>	<input type="checkbox"/>	Acid reflux/GERD
<input type="checkbox"/>	<input type="checkbox"/>	Allergies, list: _____
<input type="checkbox"/>	<input type="checkbox"/>	Amputation, site: _____
<input type="checkbox"/>	<input type="checkbox"/>	Anemia <input type="checkbox"/> Severe <input type="checkbox"/> Moderate <input type="checkbox"/> Mild
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis, type: _____
<input type="checkbox"/>	<input type="checkbox"/>	Bed sore(s) (Decubitus), location: _____
<input type="checkbox"/>	<input type="checkbox"/>	Blood pressure <input type="checkbox"/> High <input type="checkbox"/> Low
<input type="checkbox"/>	<input type="checkbox"/>	Broken bones/fractures, location: _____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer, site: _____
<input type="checkbox"/>	<input type="checkbox"/>	Chlamydia
<input type="checkbox"/>	<input type="checkbox"/>	Cholesterol <input type="checkbox"/> High <input type="checkbox"/> Low
<input type="checkbox"/>	<input type="checkbox"/>	Dehydration
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes <input type="checkbox"/> IDDM <input type="checkbox"/> NIDDM
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness <input type="checkbox"/> Constant <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional <input type="checkbox"/> Rare
<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia
<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder <input type="checkbox"/> Removal <input type="checkbox"/> Problems
<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea
<input type="checkbox"/>	<input type="checkbox"/>	Heart problems <input type="checkbox"/> Pacemaker <input type="checkbox"/> CHF <input type="checkbox"/> MI <input type="checkbox"/> Other
<input type="checkbox"/>	<input type="checkbox"/>	Head, brain, or spinal cord trauma
<input type="checkbox"/>	<input type="checkbox"/>	Herpes
<input type="checkbox"/>	<input type="checkbox"/>	Human Immunodeficiency Virus (HIV)
<input type="checkbox"/>	<input type="checkbox"/>	Human Papilloma Virus (HPV)/Genital warts
<input type="checkbox"/>	<input type="checkbox"/>	Incontinence, bladder <input type="checkbox"/> Constant <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional <input type="checkbox"/> Rare
<input type="checkbox"/>	<input type="checkbox"/>	Incontinence, bowel <input type="checkbox"/> Constant <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional <input type="checkbox"/> Rare
<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems or renal disease End stage? <input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/>	<input type="checkbox"/>	Liver problems <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Lung problems <input type="checkbox"/> Emphysema <input type="checkbox"/> Asthma <input type="checkbox"/> Pneumonia <input type="checkbox"/> COPD
<input type="checkbox"/>	<input type="checkbox"/>	Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's disease
<input type="checkbox"/>	<input type="checkbox"/>	Paralysis <input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Local, site: _____
<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder, type & frequency: _____

**F. HEALTH CONDITIONS & THERAPIES SECTION, CONTINUED**

Past	Current	Health Conditions
<input type="checkbox"/>	<input type="checkbox"/>	Shingles
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/CVA
<input type="checkbox"/>	<input type="checkbox"/>	Syphilis
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems/Graves/Myxedema <input type="checkbox"/> Hyper <input type="checkbox"/> Hypo
<input type="checkbox"/>	<input type="checkbox"/>	Tumor(s), site: _____
<input type="checkbox"/>	<input type="checkbox"/>	Ulcer(s), site: _____
<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Infection (UTI)
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

75. Provide information on the frequency of current therapies or specialty care:

Treatment type:	N/A or None	Monthly	Weekly	Several times a week	Daily	Several times a day
a. Bladder/bowel treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Catheter, type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Insulin assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. IV Fluids/IV Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Occupational therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Ostomy, site: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Oxygen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Physical therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Radiation/Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Respiratory therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Skilled nursing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Speech therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Suctioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Tube feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Wound care/Lesion irrigation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Other therapy, type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Notes & Summary:**



**G. MENTAL HEALTH SECTION**

**ASSESSOR/CM: If the client is not answering questions, skip to Question 81 and check:**

76. How satisfied are you with your overall quality of life?  Very satisfied  Satisfied  
 Neither satisfied nor dissatisfied  Dissatisfied  Very dissatisfied

77. Thinking about how you were this time last year, how do you feel about the way things are now?  
 Much better  Better  About the same  Worse  Much worse

78. Over the past two weeks, how often have you been bothered by any of the following problems?  
*(Adapted from the Patient Health Questionnaire PHQ-9, © Pfizer)*

	Not at all	Several days	More than half the days	Nearly every day
--	------------	--------------	-------------------------	------------------

a. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Moving or speaking so slowly that other people noticed – Or, the opposite, being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*\*Thoughts of suicide or self-injury, hallucinations, or aggressive behaviors are potentially serious problems that should be reported immediately to a supervisor, primary care physician, emergency care, law enforcement, and/or Adult Protective Services, as appropriate.*

**ASSESSOR/CM: If the client answered “Not at all” to a-i above, skip to Question 81.**

79. How difficult have these problems made it for you in your daily life activities and interactions with others?  
 Not difficult at all  Somewhat difficult  Very difficult  Extremely difficult

80. Are you currently working with a professional to help with this condition?  No  Yes *(Skip to 81)*

a. Have you or do you plan to discuss these issues with a professional?  No  Yes *(Skip to 81)*

b. Do you talk about any of these issues with anyone else you know?  No  Yes

81. Have you been diagnosed with a mental condition or psychiatric disorder by a health professional?

No *(Skip to 82)*  Yes: *List conditions:* \_\_\_\_\_

**G. MENTAL HEALTH SECTION, CONTINUED**

82. **ASSESSOR/CM:** Indicate whether you noticed problem behaviors or any recurring problems have been reported to you by the client, caregiver, in-home worker, family, or staff, and note the frequency of occurrence in the last month. Provide details in the Notes & Summary section, below.

Problem behaviors	Not at all	Once	Several days	More than half the days	Nearly every day
a. Forgetful or easily confused	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Gets lost or wanders off	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Easily agitated or disruptive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Sexually inappropriate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Threatens or is verbally hostile*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Physically aggressive or violent*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Intentionally injures or harms him/herself*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Expresses suicidal feelings or plans*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Hallucinates, hears/sees things that are not there*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*\*Thoughts of suicide or self-injury, hallucinations, or aggressive behaviors are potentially serious problems that should be reported immediately to a supervisor, primary care physician, emergency care, law enforcement, and/or Adult Protective Services, as appropriate.*

83. **ASSESSOR/CM: Does client need supervision?**  No  Yes

**Notes & Summary:**

**H. RESIDENTIAL LIVING ENVIRONMENT SECTION**

84. **ASSESSOR/CM:** If information about the client's residence is reported to you, without your observation, check here  and all that apply below. If residence issues are directly observed by you, use the list below to observe and check off the specific issue(s) with the potential for safety or accessibility problems.

**Check all that apply:**

- a. Exterior issues(s):       Road       Driveway       Yard       Ramp       Windows       Roof
- b. Interior issues(s):       Doors       Stairs       Floor       Walls       Ceiling       Lights
- c. Restroom issues(s):       Door       Handrails       Tub       Shower       Toilet
- d. Utility issue(s):       Plumbing       Water       Electric       Gas
- e. Furniture issue(s):       Chair       Couch       Bed       Table
- f. Telephone issue(s):       Broken       No phone       Disconnected/No service
- g. Temperature issue(s):       Heat       Smoke detector       Air conditioning
- h. Unsanitary condition(s):       Odors       Insects       Rodents  
     Accumulating items or garbage       Floors or pathways cluttered

i. Other hazards: \_\_\_\_\_

85. Is there a pet in your home or yard?       No (Skip to 86)       Yes

a. Please specify the type and size: \_\_\_\_\_

b. **ASSESSOR/CM: Pet comments/concerns:** \_\_\_\_\_

86. **ASSESSOR/CM: Please rate the level of risk in the client's residential living environment:**

- No/low apparent risk from current living conditions.
- Minor risk (One or more aspects are substandard and should be addressed in the following year to avoid potential injury.)
- Moderate risk (Major aspects are substandard and must be addressed in the next few months to remain in home safely.)
- High risk (Serious hazards are present. The client must change dwellings or immediate corrective action must be taken to correct the issues noted above.)

**Notes & Summary:**

**I. NUTRITION SECTION**

87. Do you usually eat at least two meals a day?  No  Yes

88. On a typical day, what types of food do you eat for:

a. Breakfast: \_\_\_\_\_

b. Lunch: \_\_\_\_\_

c. Dinner: \_\_\_\_\_

d. Snacks: \_\_\_\_\_

89. Do you eat alone most of the time?  No  Yes

90. How many cups of water, juice, or other liquid do you drink daily? (If more than eight, skip to 91) # \_\_\_\_\_

a. Do you ever limit the amount of fluids you drink?  No (Skip to 91)  Yes

b. Why and when do you limit the fluids you intake? \_\_\_\_\_

91. On average, how many servings of fruits and vegetables do you eat every day? (One "serving" is one small piece of fruit or vegetable, about one-half cup of chopped fruit or vegetable, or one-half cup of fruit or vegetable juice.) # \_\_\_\_\_

92. On average, how many servings of dairy products do you have every day? (One "serving" of dairy is about a slice of cheese, a cup of yogurt, or a cup of milk or dairy substitute.) # \_\_\_\_\_

93. Estimate your current height and weight: Height: \_\_\_\_\_ ft. \_\_\_\_\_ inches Weight: \_\_\_\_\_ lbs.

94. Have you lost or gained weight in the last few months?  Unsure (Skip to 95)  No (Skip to 95)  Yes

a. How much?  Less than five pounds  Five to ten pounds  Ten pounds or more

b. Was the weight loss/gain on purpose (i.e., dieting or trying to lose/gain weight)?  No  Yes

95. Are you on a special diet(s) for medical reasons?  No (Skip to 96)  Yes; check any/all:

Calorie supplement  Low fat/cholesterol  Low salt/sodium  Low sugar/carb  Other

a. How long have you been on this diet? \_\_\_\_\_

b. Why are you on this diet? \_\_\_\_\_

96. Do you have any problems that make it hard for you to chew or swallow?  No  Yes; check any/all:

Mouth/tooth/dentures  Pain or difficulty swallowing  Taste  Nausea

Saliva production  Other, describe: \_\_\_\_\_

97. What working appliances do you have for storing/preparing food?  None

Refrigerator  Microwave  Toaster/Oven  Stove  Other: \_\_\_\_\_

**Notes & Summary:**

**J. MEDICATIONS & SUBSTANCE USE SECTION**

98. Do you take three or more prescribed or over-the-counter medications a day?  No  Yes

99. May I see all the medications you take, both regularly and those taken only as needed? Also, please show me all types of over-the-counter medications and any supplements that you regularly take.

**ASSESSOR/CM: Check the original bottles in the medicine cabinet, nightstand, and refrigerator, as well as non-prescription drugs, over the counter drugs, sleep aids, herbal remedies, vitamins, and supplements.**

Medication name	Prescribed dose	Prescribed Frequency	Taken as prescribed? Yes/No*	Administration method	Prescriber name

If you have a printed list of meds managed by a facility, attach sheet. If there are more medications to record, use the Notes & Summary section or a blank sheet of paper to write the information.

100. **\*ASSESSOR/CM: Only ask when the client is not taking medications as indicated: "Why do you take [name of medication] differently than prescribed?" and explain each below:**

- Medication and reason: \_\_\_\_\_
- Medication and reason: \_\_\_\_\_
- Medication and reason: \_\_\_\_\_
- Medication and reason: \_\_\_\_\_
- Medication and reason: \_\_\_\_\_
- Medication and reason: \_\_\_\_\_
- Medication and reason: \_\_\_\_\_
- Medication and reason: \_\_\_\_\_
- Medication and reason: \_\_\_\_\_
- Medication and reason: \_\_\_\_\_
- Medication and reason: \_\_\_\_\_

**J. MEDICATIONS & SUBSTANCE USE SECTION, CONTINUED**

101. Please list the doctors you usually go to for treatment and medications:

Physician name	Phone number	Approx. date of last visit	Reason for last visit:

If you have more than ten physicians to record, use the Notes & Summary section or a blank sheet of paper to write the information.

102. What pharmacies or drug stores do you use? \_\_\_\_\_

103. Are you able to tell the difference between your pills (*i.e., colors, shapes, print*)?  No  Yes  N/A

104. **ASSESSOR/CM: Are the client's medications managed by a facility/caregiver?**  No  Yes  N/A

105. **ASSESSOR/CM: In your opinion, are the client's medications managed properly?**  No  Yes  N/A

106. **ASSESSOR/CM: Should client have a new medication review by a doctor or pharmacist?**  No  Yes  N/A

107. How many days in a typical week do you drink alcohol?  
 Refused (*Skip to 108*)  None (*Skip to 108*)  One to two  Three to five  Six to seven

a. On the days when you have some alcohol, about how many drinks do you usually have?

One to two (*Skip to 108*)  Three to five  Six or more

b. About how many times in the last month have you had four or more drinks in a day?

None  One to two  Three to five  Six or more

108. Have you used any form of tobacco in the last six months?  No (*Skip to 109*)  Yes:

a. What type(s)?  Chewing tobacco  Cigarettes  Cigars  Snuff  Other

b. About how many times do you use tobacco each day?

One to three  Four to ten  Eleven or more

109. Do you regularly use drugs other than those required for medical reasons (*i.e., controlled substances or "street drugs"*)?  Refused (*Skip to 110*)  No (*Skip to 110*)  Yes, what type(s):

a. About how often do you use these?  Rarely  Less than twice a month  
 Less than once a week  Several times a week  Daily  Several times a day

b. How long have you been using that often?  Less than a year  One or more years

**Notes & Summary:**

**K. SOCIAL RESOURCES SECTION**

110. If needed, is there someone (besides the primary caregiver) who could help you?  No (Skip to 112)  Yes

111. Do I have your permission to contact this person, if you need help?  No (Skip to 112)  Yes

a. Name: \_\_\_\_\_ b. Relationship to client: \_\_\_\_\_

c. Phone: \_\_\_\_\_

About how often do you:	Once a day	Two to six times a week	Once a week	Several times a month	Every few months	A few times a year	Never
112. Talk to friends, relatives, or others (by phone, computer, or other means)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
113. Spend time with someone who does not live with you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
114. Participate in activities outside the home that interest you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**L. CAREGIVER SECTION**

**ASSESSOR/CM: If client has no caregiver, stop the assessment here. If client has a caregiver, complete 115-136.**

115. **ASSESSOR/CM: HCE Caregiver? If yes, check**

116. Caregiver full name: a. First: \_\_\_\_\_  
 b. Middle Initial: \_\_\_\_\_ c. Last: \_\_\_\_\_

117. Caregiver date of birth: (mm/dd/yyyy) \_\_\_\_\_

118. **ASSESSOR/CM: Caregiver identification number** \_\_\_\_\_

119. Caregiver sex:  Male  Female

120. Caregiver race (Mark all that apply):  White  Black/African American  Asian  
 American Indian/ Alaska Native  Native Hawaiian/ Pacific Islander  Other

121. Caregiver ethnicity:  Hispanic or Latino  Other

122. Caregiver primary language:  English  Spanish  Other \_\_\_\_\_

123. Caregiver relationship to client:  
 Wife  Husband  Partner  Parent  
 Son/In-law  Daughter/In-law  Other relative  Other Non-relative

124. Caregiver address:  
 a. Street: \_\_\_\_\_  
 b. City: \_\_\_\_\_ c. State: \_\_\_\_\_ d. ZIP code: \_\_\_\_\_

125. Caregiver phone number: \_\_\_\_\_

126. Do you work outside the home?  No  Yes:  Full-time  Part-time

127. Do you currently have anyone to assist you with providing care?  No (Skip to 129)  Yes

**L. CAREGIVER SECTION, CONTINUED**

128. Do I have your permission to contact this person if for some reason you are unable to provide care for the client?  No (*Skip to 129*)  Yes, please provide the name and relationship to client:

a. First name: \_\_\_\_\_ b. Last name: \_\_\_\_\_

c. Phone: \_\_\_\_\_ d. Relationship to client:  Wife  Husband  Partner  
 Parent  Son/In-law  Daughter/In-law  Other relative  Other Non-relative

129. How long have you been providing care for this client?

Less than six months  Six to twelve months  One to two years  Two or more years

130. How many hours per week do you currently spend providing care for the client?

# \_\_\_\_\_

131. Do you need training or assistance in performing caregiving tasks?  No  Yes, please describe:

132. How much of a mental or emotional strain is it on you to provide care for the client?

None  Some strain  A lot of strain

133. Considering other aspects of your life, please rate the level of difficulty in your:

No difficulty Little difficulty Some difficulty Moderate difficulty A lot of difficulty

	No difficulty	Little difficulty	Some difficulty	Moderate difficulty	A lot of difficulty
a. Relationship with client	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Relationship with family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Relationships with friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Physical health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Finances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Functional abilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Time for yourself to do the things you enjoy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

134. How confident are you that you will have the ability to continue to provide care?

Very confident (*Skip to 135*)  Somewhat confident (*Skip to 135*)  Not very confident

a. What is the main reason you may be unable to continue to provide care? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

135. Assessor/CM: Is the caregiver in crisis?

No  Yes; check all that apply:  
 Financial  Emotional  Physical



**L. CAREGIVER SECTION, CONTINUED**

136. Ask the caregiver to answer the following about the client. (An answer of "Yes, a change" indicates that there has been a change in the last year caused by thinking and memory problems.)	Yes, a change	No change	Don't know or N/A
a. Problems with judgment (problems making decisions, bad financial decisions, problems with thinking)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Less interest in hobbies/activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Repeats the same things over and over (questions, stories, or statements)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Trouble learning how to use a tool, appliance, or gadget (TV, radio, microwave, remote control)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Forgets the correct month or year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Trouble handling complicated financial affairs (balancing checkbook, income taxes, paying bills)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble remembering appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Daily problems with thinking or memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Adapted from the "Eight-item Informant Interview to Differentiate Aging and Dementia," a copyrighted instrument of Washington University, St. Louis, Missouri. Copyright 2005. All rights reserved.*

**Notes & Summary:**

[This page is intentionally left blank]

## WHY ARE WE COLLECTING YOUR SOCIAL SECURITY NUMBER?

We are required to explain that your Social Security number is being collected pursuant to Title 42 Code of Federal Regulations, Section 435.910, to be used for screening and referral to programs or services that may be appropriate for you.

The provision of your Social Security number is voluntary, and your information will remain confidential and protected under penalty of law. We will not use or give out your Social Security number for any other reason unless you have signed a separate consent form that releases us to do so.