Choices for Care Clinical Assessment

A. ASSESSMENT INFORMATION

1. Date: _____ 2. Interview: ☐Phone, or ☐In Person (where)_____

3. Applicant Name: _____
a. *(Last)* *b. (First)* *c. (M.I.)*

4. Mailing Address (if different from application form):

_____
Street/P.O. Box State Zip

5. Did anyone other than the applicant help answer questions? a. ☐Yes b. ☐No

6. If "Yes", name and relationship of the person(s): _____

B. ACTIVITIES OF DAILY LIVING (ADL's)

Code for individuals actual level of involvement in self-care over 24 hours for the last 7 days.

1. **TOILET USE:** How the individual uses the toilet, commode, bedpan, urinal; transferring on/off toilet, cleansing self, managing incontinence pad(s), managing ostomy or catheter, adjusting clothes.

☐0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
☐1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
☐2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
☐3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
☐4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

Comments:

2. **EATING:** How the individual eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g. tube feeding, total parenteral nutrition).

☐0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
☐1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
☐2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
☐3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
☐4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

Comments:

3. **BED MOBILITY:** How the individual moves to and from lying position, turning side-to-side, and positioning body while in bed.

☐0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
☐1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
☐2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
☐3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
☐4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

Comments:

4.**TRANSFERRING:** How the individual moves between surfaces – to/from bed, chair, wheelchair, standing position , EXCLUDES to/from /toilet.)

- ☐0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
- ☐1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
- ☐2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
- ☐3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
- ☐4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
- ☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

Comments:

5.**BATHING:** How the individual takes a full-body bath/shower, sponge bath, washing/drying face, hands and perineum. (excluding back and hair)

- ☐0 - **Independent:** No help provided
- ☐1 - **Supervision:** Oversight/cueing only
- ☐2 - **Limited Assist:** Physical help limited to transfer only
- ☐3 - **Extensive Assist:** Physical help in part of bathing activity
- ☐4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
- ☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

Comments:

6.**DRESSING:** How the individual puts on, fastens, and takes off all items of clothing, including donning/removing prosthesis.

- ☐0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
- ☐1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
- ☐2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
- ☐3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
- ☐4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
- ☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

Comments:

7.**MOBILITY:** How the individual moves between locations in room, outside room and to distant areas of building. If in wheelchair, self-sufficiency once in wheelchair.

- ☐0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
- ☐1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
- ☐2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
- ☐3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
- ☐4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
- ☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

Comments:

8. **PERSONAL HYGIENE:** During the last 7 days, how would you rate the individual's ability to perform personal hygiene? (Combing hair, brushing teeth, shaving, washing/drying face, hands, and perineum, EXCLUDE baths and showers.)

- ☐ 0 - **Independent:** No help at all—**OR**—help/oversight provided only 1 or 2 times
- ☐ 1 - **Supervision:** Oversight/cueing 3 + times—**OR**— oversight/cueing plus physical help 1 or 2 times
- ☐ 2 - **Limited Assist:** Non-wt. bearing physical help 3 + times—**OR**—non-wt. bearing physical help plus extensive help 1 or 2 times
- ☐ 3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
- ☐ 4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
- ☐ 8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

Comments:

9. **ADAPTIVE DEVICES:** During the last 7 days, how would you rate the individual's ability to manage putting on and removing braces, splints, and other adaptive devices?

- ☐ 0 - **Independent:** No help at all—**OR**—help/oversight provided only 1 or 2 times
- ☐ 1 - **Supervision:** Oversight/cueing 3 + times—**OR**— oversight/cueing plus physical help 1 or 2 times
- ☐ 2 - **Limited Assist:** Non-wt. bearing physical help 3 + times—**OR**—non-wt. bearing physical help plus extensive help 1 or 2 times
- ☐ 3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
- ☐ 4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
- ☐ 8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

Comments:

10. **MEAL PREPARATION:** During the last 7 days, how would you rate the individual's ability to perform meal preparation? (Planning and preparing light meals or reheating delivered meals.)

- ☐ 0 - **Independent:** No help provided (With/without assistive devices)
- ☐ 1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐ 2 – **Done by Others**: Full caregiver assistance.
- ☐ 8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

Comments:

11. **MEDICATIONS:** During the last 7 days, how would you rate the individual's ability to manage medications? (Preparing and taking all prescribed and over the counter medications reliably and safely, including the correct dosage at appropriate times/intervals.)

- ☐ 0 - **Independent:** No help provided (With/without assistive devices)
- ☐ 1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐ 2 – **Done by Others**: Full caregiver assistance.
- ☐ 8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

Comments:

NOTE: If no activity scores "Total Dependence" (4) and only one activity scores "Extensive Assist" (3), describe the intensity and frequency of assistance needed in the comments section.

C. COGNITION and MEMORY

1. Memory and use of information:
   - A. ☐ Does not have difficulty remembering and using information. Does not require directions or reminding from others.
   - B. ☐ Has minimal difficulty remembering and using information. Requires direction and reminding from others 1 to 3 times per day. Does not have to do with memory
   - C. ☐ Has difficulty remembering and using information. Requires direction and reminding from others 4 or more times per day.
   - D. ☐ Cannot remember or use information. Requires continual verbal reminding.

2. Cognitive Skills for Daily Decision-Making
   - a. ☐ Independent – decisions consistent/reasonable
   - b. ☐ Modified independence – some difficulty in new situations only
   - c. ☐ Moderately impaired – decision poor/cues/supervision required
   - d. ☐ Severely impaired – never/rarely makes decisions

Comments:

D. BEHAVIOR SYMPTOMS:

1.a. How often does the individual get lost or wander? (Moves with no rational purpose, seemingly oblivious to needs or safety.) ☐ 0 – Never ☐ 1 – Less than daily ☐ 2 – Daily

1.b. In the last 7 days, was the wandering easily altered?
☐ 0 – Behavior was not present -**OR**- was easily altered ☐ 1 – Behavior was NOT easily altered

2.a. How often is the individual verbally abusive to others? (Others were threatened, screamed at, cursed at.)
☐ 0 – Never ☐ 1 – Less than daily ☐ 2 – Daily

2.b. In the last 7 days, was the verbal abuse easily altered?
☐ 0 – Behavior was not present -**OR**- was easily altered ☐ 1 – Behavior was NOT easily altered

3.a. How often is the individual physically abusive to others? (Others were hit, shoved, scratched, sexually abused.)
☐ 0 – Never ☐ 1 – Less than daily ☐ 2 – Daily

3.b. In the last 7 days, was the physical abuse easily altered?
☐ 0 – Behavior was not present -**OR**- was easily altered ☐ 1 – Behavior was NOT easily altered

4.a. How often does the individual exhibit socially inappropriate/disruptive behavior? (Makes disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings.)
☐ 0 – Never ☐ 1 – Less than daily ☐ 2 – Daily

4.b. In the last 7 days, was the socially disruptive behavior easily altered?
☐ 0 – Behavior was not present -**OR**- was easily altered ☐ 1 – Behavior was NOT easily altered

5.a. How often did the individual display symptoms of resisting care? (Resists taking medications/injections, ADL assistance, or eating.)
☐ 0 – Never ☐ 1 – Less than daily ☐ 2 – Daily

5.b. In the last 7 days, was the resisting care behavior easily altered?
☐ 0 – Behavior was not present -**OR**- was easily altered ☐ 1 – Behavior was NOT easily altered

F. MEDICAL INFORMATION

1. **Medical Diagnosis:** List only current medical conditions for which the individual is receiving services/treatments.

_____

_____

2. **Disease Diagnosis:** *Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses.)*

A. ☐ Aphasia
B. ☐ Cerebral palsy
C. ☐ Dementia other than Alzheimer's disease
D. ☐ Multiple sclerosis
E. ☐ Quadriplegia
F. ☐ Traumatic brain injury
G. ☐ Emphysema/COPD
H. ☐ Renal failure
I. ☐ OTHER-List:
J. ☐ OTHER-List:
K. ☐ NONE OF THE ABOVE

3. **Infections:** *Check all that apply*. If none apply, check the NONE OF THE ABOVE box.

A. ☐ Pneumonia
B. ☐ Respiratory infection
C. ☐ Septicemia
D. ☐ OTHER-List:
E. ☐ OTHER-List:
F. ☐ NONE OF THE ABOVE

4. **Problem Conditions:** *Check all problems present in the last 7 days.*

A. ☐ Dehydration
B. ☐ Dizziness/Vertigo
C. ☐ Recurrent lung aspirations ***in last 90 days***
D. ☐ Shortness of breath
E. ☐ Syncope (fainting)
F. ☐ Unsteady gait
G. ☐ End stage disease, 6 or fewer months to live
H. ☐ OTHER-List:
I. ☐ OTHER-List:
J. ☐ NONE OF THE ABOVE

5. **Special Care/Treatments:** *Check all treatments received during the last 14 days.*

A. ☐ Chemotherapy
B. ☐ Dialysis
C. ☐ IV meds
D. ☐ Oxygen therapy
E. ☐ Radiation
F. ☐ OTHER-List:
G. ☐ OTHER-List:
H. ☐ NONE OF THE ABOVE

6.a. **Therapies:** *Check all therapies received in last 7 days.*

A. ☐ Speech Therapy
B. ☐ Occupational Therapy
C. ☐ Physical Therapy
D. ☐ Respiratory Therapy
E. ☐ NONE OF THE ABOVE

6.b. Does the individual currently receive at least 15minutes/day of PT, ST RT or OT or a combination of that equals skilled teaching on a daily basis.?

A. ☐ Yes B. ☐ No C. ☐ info. unavailable

7. **Nutrition:** Check all nutritional issues in the last 7 days. *(Mark all that apply)*

A. ☐ Parenteral/IV
B. ☐ Feeding tube
C. ☐ OTHER: List
D. ☐ OTHER-List:
E. ☐ NONE OF THE ABOVE

8.a. **Pain Status:** What is the frequency of pain interfering with individual's activity or movement? C*heck one.*

A. ☐ Individual has **no** pain or pain does **not** interfere with activity or movement
B. ☐ Less often than daily
C. ☐ Daily, but not constantly
D. ☐ All of the time
E. ☐ Info. unavailable

8.b. Is the individual experiencing pain that is not easily relieved, occurs at least daily, and affects the individual's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity? A. ☐Yes B. ☐No C. ☐info unavailable

9.a. **Ulcers:** Record the number of ulcers (due to any cause) at each ulcer stage on any part of the body. Specify "0" if no pressure ulcer(s).

A. **Stage 1**: ____ A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.
B. **Stage 2**: ____ A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.
C. **Stage 3**: ____ A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.
D. **Stage 4**: ____ A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

9.b. Indicate which of the following skin problems the individual has that requires treatment. *Check all that apply during last 7 days.*

A. ☐Burns (second or third)
B. ☐Open lesions other than ulcers, rashes, cuts (e.g. cancer lesions)
C. ☐Surgical wounds
D. ☐NONE OF THE ABOVE

10.a. **Urinary Status:** Does the individual have urinary incontinence?

A. ☐ Yes
B. ☐ No incontinence and no urinary catheter
C. ☐ No incontinence, individual has urinary catheter

If answer is B. or C., go to question #11.a.

10.b. What is the frequency of urinary incontinence?

A. ☐ less than once weekly
B. ☐ one to three times weekly
C. ☐ four to six times weekly
D. ☐ one to three times daily
E. ☐ four or more times daily

10.c. When does urinary incontinence occur?

A. ☐ during the day only B. ☐ during the night only C. ☐ during the day and night

11.a.. **Bowel Status:** Does the individual have bowel incontinence?

A. ☐ Yes
B. ☐ No incontinence and no ostomy
C. ☐ No incontinence, individual has an ostomy

If answer is B. or C., skip 11.b and 11.c.

11.b. What is the frequency of bowel incontinence?

A. ☐ less than once weekly
B. ☐ one to three times weekly
C. ☐ four to six times weekly
D. ☐ one to three times daily
E. ☐ four or more times daily

11.c. When does bowel incontinence occur?

A. ☐ during the day only B. ☐ during the night only C. ☐ during the day and night

Comments_____

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DAIL LTCCC signature: _____ Date: _____

KEY: Activities of Daily Living (ADL), Self-Performance

0 = Independent – No help or oversight **–OR-** help/oversight provided only 1 or 2 times during the last seven days.

1 = Supervision – Oversight, encouragement or cueing provided 3 or more times**—OR—** Supervision (3 or more times) plus limited physical assistance provided only 1 or 2 times during the last seven days.

2 = Limited Assistance – Individual highly involved in activity, received physical help in guided maneuvering of limbs, or other non-weight bearing assistance 3 or more times**—OR—**Limited assistance (3 or more times) plus extensive assistance provided only 1 or 2 times in the last 7 days.

3 = Extensive Assistance – While individual performed part of activity, weight-bearing support or full caregiver performance 3 or more times over part (but not all) of the last seven days.

4 = Total Dependence –Full caregiver performance of the activity each time the activity occurred during the entire seven-day period. There is complete non-participation by the individual in all aspects of the ADL definition task. If the caregiver performed an activity for the individual during the entire observation period, but the individual performed part of an activity him/herself, it would NOT be coded as a "4" Total Dependence.

BATHING Self-Performance Key– Due to the nature and frequency of the bathing activity, the following self-performance scale is used.

0 = Independent – No help or oversight provided.

1 = Supervision – Oversight, encouragement or cueing only.

2 = Limited Assistance – Individual highly involved in activity, received physical help to transfer only.

3 = Extensive Assistance – While individual performed part of activity, physical help in part of the activity was provided.

4 = Total Dependence –Full caregiver performance of the activity each time the activity occurred during the entire seven-day period. There is complete non-participation by the individual in all aspects of the ADL definition task. If the caregiver performed an activity for the individual during the entire observation period, but the individual performed part of an activity him/herself, it would NOT be coded as a "4" Total Dependence.