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	☐	☐	☐	☐	☐
b. Dressing	☐	☐	☐	☐	☐
c. Eating	☐	☐	☐	☐	☐
d. Using the bathroom	☐	☐	☐	☐	☐
e. Transferring	☐	☐	☐	☐	☐
f. Walking/Mobility	☐	☐	☐	☐	☐

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	☐	☐	☐	☐	☐
b. Dressing	☐	☐	☐	☐	☐
c. Eating	☐	☐	☐	☐	☐
d. Using the bathroom	☐	☐	☐	☐	☐
e. Transferring	☐	☐	☐	☐	☐
f. Walking/Mobility	☐	☐	☐	☐	☐

Notes & Summary:

E. INSTRUMENTAL ACTIVITIES OF DAILY LIVING SECTION

71. How much assistance do you <u>need</u> 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	☐	☐	☐	☐	☐
b. Light housekeeping	☐	☐	☐	☐	☐
c. Using the telephone	☐	☐	☐	☐	☐
d. Managing money	☐	☐	☐	☐	☐
e. Preparing meals	☐	☐	☐	☐	☐
f. Shopping	☐	☐	☐	☐	☐
g. Managing medication	☐	☐	☐	☐	☐
h. Using transportation	☐	☐	☐	☐	☐

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 <u>have</u> 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	☐	☐	☐	☐	☐
b. Light housekeeping	☐	☐	☐	☐	☐
c. Using the telephone	☐	☐	☐	☐	☐
d. Managing money	☐	☐	☐	☐	☐
e. Preparing meals	☐	☐	☐	☐	☐
f. Shopping	☐	☐	☐	☐	☐
g. Managing medication	☐	☐	☐	☐	☐
h. Using transportation	☐	☐	☐	☐	☐

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

F. HEALTH CONDITIONS & THERAPIES SECTION, CONTINUED

Past	Current	Health Conditions
☐	☐	Shingles
☐	☐	Stroke/CVA
☐	☐	Syphilis
☐	☐	Thyroid problems/Graves/Myxedema ☐ Hyper ☐ Hypo
☐	☐	Tumor(s), site: _____
☐	☐	Ulcer(s), site: _____
☐	☐	Urinary Tract Infection (UTI)
☐	☐	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	☐	☐	☐	☐	☐	☐
b. Catheter, type: _____	☐	☐	☐	☐	☐	☐
c. Dialysis	☐	☐	☐	☐	☐	☐
d. Insulin assistance	☐	☐	☐	☐	☐	☐
e. IV Fluids/IV Medications	☐	☐	☐	☐	☐	☐
f. Occupational therapy	☐	☐	☐	☐	☐	☐
g. Ostomy, site: _____	☐	☐	☐	☐	☐	☐
h. Oxygen	☐	☐	☐	☐	☐	☐
i. Physical therapy	☐	☐	☐	☐	☐	☐
j. Radiation/Chemotherapy	☐	☐	☐	☐	☐	☐
k. Respiratory therapy	☐	☐	☐	☐	☐	☐
l. Skilled nursing	☐	☐	☐	☐	☐	☐
m. Speech therapy	☐	☐	☐	☐	☐	☐
n. Suctioning	☐	☐	☐	☐	☐	☐
o. Tube feeding	☐	☐	☐	☐	☐	☐
p. Wound care/Lesion irrigation	☐	☐	☐	☐	☐	☐
q. Other therapy, type:	☐	☐	☐	☐	☐	☐

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 <u>bothered</u> 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	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
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	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way*	☐	☐	☐	☐

**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	☐	☐	☐	☐	☐
b. Gets lost or wanders off	☐	☐	☐	☐	☐
c. Easily agitated or disruptive	☐	☐	☐	☐	☐
d. Sexually inappropriate	☐	☐	☐	☐	☐
e. Threatens or is verbally hostile*	☐	☐	☐	☐	☐
f. Physically aggressive or violent*	☐	☐	☐	☐	☐
g. Intentionally injures or harms him/herself*	☐	☐	☐	☐	☐
h. Expresses suicidal feelings or plans*	☐	☐	☐	☐	☐
i. Hallucinates, hears/sees things that are not there*	☐	☐	☐	☐	☐
j. Other:	☐	☐	☐	☐	☐

**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 <u>not</u> 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: _____
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)?	☐	☐	☐	☐	☐	☐	☐
113. Spend time with someone who does not live with you?	☐	☐	☐	☐	☐	☐	☐
114. Participate in activities outside the home that interest you?	☐	☐	☐	☐	☐	☐	☐

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
a. Relationship with client	☐	☐	☐	☐	☐
b. Relationship with family	☐	☐	☐	☐	☐
c. Relationships with friends	☐	☐	☐	☐	☐
d. Physical health	☐	☐	☐	☐	☐
e. Finances	☐	☐	☐	☐	☐
f. Functional abilities	☐	☐	☐	☐	☐
g. Employment	☐	☐	☐	☐	☐
h. Time for yourself to do the things you enjoy	☐	☐	☐	☐	☐

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)	☐	☐	☐
b. Less interest in hobbies/activities	☐	☐	☐
c. Repeats the same things over and over (questions, stories, or statements)	☐	☐	☐
d. Trouble learning how to use a tool, appliance, or gadget (TV, radio, microwave, remote control)	☐	☐	☐
e. Forgets the correct month or year	☐	☐	☐
f. Trouble handling complicated financial affairs (balancing checkbook, income taxes, paying bills)	☐	☐	☐
g. Trouble remembering appointments	☐	☐	☐
h. Daily problems with thinking or memory	☐	☐	☐

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Notes & Summary: