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MASSACHUSETTS REAL CHOICE FUNCTIONAL NEEDS ASSESSMENT

SECTION A: AGENCY/ORGANIZATION INFORMATION

Date of Request or Referral: _____ **Date Assessment Completed**: _____
Month/Day/Year Month/Day/Year

Assessor Name: _____ **Assessor Agency**: _____

Assessor ID: _____ **Assessor Title**: _____

SECTION B: INITIAL SCREENING AND INTAKE

SPECIAL ACCOMMODATIONS REQUIRED TO COMPLETE ASSESSMENT:

❒ large print ❒ interpreter for hearing ❒ other _____
❒ Braille ❒ language interpreter ❒ other _____

PERSON PROVIDING ANSWERS AND INFORMATION FOR ASSESSMENT:

❒ consumer ❒ friend/neighbor ❒ legal guardian or surrogate decision-maker
❒ family member ❒ other professional (e.g. care manager) ❒ health record

CONSUMER HAS BEEN INFORMED OF THE APPEAL(S) PROCESS FOR THE OUTCOME OF THIS ASSESSMENT:

❒ yes ❒ no

DATE INFORMED OF APPEAL(S) PROCESS: _____
Month/Day/Year

PRIMARY LANGUAGE:

❒ English ❒ Spanish ❒ French ❒ Other _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Address: _____
Town: _____ State: _____ Zip Code: _____ Phone: _____
Relationship to Client: _____

SECTION C. CONSUMER INFORMATION

Social Security Number: ☐☐☐-☐☐-☐☐☐☐ **Medicare Number**: ☐☐☐☐☐☐☐☐☐☐☐☐

Mass Health Number: ☐☐☐☐☐☐☐☐☐☐☐☐

Last Name: _____ **First Name**: _____ **MI**: _____

Address: _____ **Apt. #**: _____ **Town**: _____

State: _____ **Zip Code**: _____ **Telephone (Home)**: _____ **Work**: _____

DOB: _____
Month/Day/Year

Gender: ❒ Male ❒ Female

Race: ❒ White
❒ Black or African American
❒ American Indian or Alaskan Native
❒ Native Hawaiian or Other Pacific Islander
❒ Asian
❒ Declined to Respond
❒ Other _____

Marital Status: ❒ Never Married
❒ Married
❒ Partner/Significant Other
❒ Widowed
❒ Separated
❒ Divorced

Ethnicity: ❒ Hispanic or Latino

Education (Highest level completed): ❒ 8th grade or less ❒ High school graduate ❒ GED (Graduate Equivalency Diploma)
❒ Technical or trade school ❒ Some college ❒ Associate's degree ❒ Bachelor's degree
❒ Graduate degree ❒ Post-secondary degree (JD, MD, Ph.D, DVM, etc.)

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Current Disability or Diagnosis:

Primary	Secondary	Diagnosis	Primary	Secondary	Diagnosis
❒	❒	Blind	❒	❒	Cerebral palsy
❒	❒	Cataract	❒	❒	Multiple sclerosis
❒	❒	Glaucoma	❒	❒	Muscular dystrophy
❒	❒	Visual impairment	❒	❒	Parkinsonism
❒	❒	Deaf	❒	❒	Polio
❒	❒	Hard of hearing	❒	❒	Amputation
❒	❒	Late deafened	❒	❒	Other orthopedic impairment
❒	❒	Oral deaf	❒	❒	Spina bifida
❒	❒	Speech impairment	❒	❒	Spinal cord injury
❒	❒	Arthritis	❒	❒	Alzheimer's disease
❒	❒	Degenerative disease	❒	❒	Dementia other than Alzheimer's disease
❒	❒	Hip fracture	❒	❒	Epilepsy
❒	❒	Osteoporosis	❒	❒	Head injury/Head trauma
❒	❒	Other fractures (e.g. wrist, vertebrae)	❒	❒	Learning disability
❒	❒	Diabetes	❒	❒	Mental retardation
❒	❒	Renal failure	❒	❒	Psychiatric disability
❒	❒	Chronic heart condition	❒	❒	Chemical dependency
❒	❒	Congestive heart failure	❒	❒	Environmental sensitivity
❒	❒	Coronary artery disease	❒	❒	HIV/AIDS
❒	❒	Hypertension	❒	❒	Hemiplegia/hemiparesis
❒	❒	Irregular pulse	❒	❒	Pneumonia
❒	❒	Stroke	❒	❒	Thyroid disease (hyper or hypo)
❒	❒	Asthma	❒	❒	Tuberculosis
❒	❒	COPD	❒	❒	Urinary tract infection (in last 30 days)
❒	❒	Emphysema	❒	❒	Other disability
❒	❒	Cancer	❒	❒	None of above

Section C: Citizenship

Consumer is a US Citizen: ❒ Yes ❒ No ❒ Other _____

If no, please answer the following questions:

1. **Are you or any family member on active duty, or a veteran of the United Stated Armed Forces with an honorable discharge, or did you or any family member serve under US command during World War II or in Vietnam?**
   ❒ Yes
   ❒ No
2. **Are you or any family member the spouse, widow or widower, or dependent of a person on active duty or a veteran described above?**
   ❒ Yes
   ❒ No
3. **Status Code**:
   ❒ Americasian admitted pursuant to Section 584 of Public Law 100-202
   ❒ Granted asylum
   ❒ Conditional entrant
   ❒ Cuban/Haitian entrant
   ❒ Deportation withheld
   ❒ Legal permanent resident
   ❒ Native American with at least 50% American Indian blood born in Canada
   ❒ Granted parole
   ❒ Refugee
   ❒ Person with a temporary visa/other
   ❒ Person residing under color of law (PRUCOL)
4. **Date citizenship status awarded**: _____ Month/Day/Year
5. **Date moved to U.S**.: _____ Month/Day/Year

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Section C: Finance and Insurance

1. ❒ **No, I don't have health insurance**

   Would you like assistance obtaining health insurance? ❒ Yes ❒ No

2. ❒ **Yes, I have health insurance (public or private)**: Please list policy numbers.

   ❒ Medicare Part A: _____ ❒ Medicare Part B: _____

   ❒ HMO: _____ ❒ Medicaid (Mass Health): _____

   ❒ Private: _____ ❒ Common Health: _____

   ❒ Other: _____

3. **Is your health insurance in your name?**
   - ❒ Yes
   - ❒ No

4. **If your insurance coverage is listed under another name or under your employer's name, please provide the name of the insured**:

   _____

5. **Are your medical needs being met by your insurer (e.g. getting wheelchairs, medical supplies, long term care insurance, getting prescription medications, etc.)?**
   - ❒ Yes
   - ❒ No

   If no, please describe why not:_____

6. **What is your annual income range, including all sources of income including child support? (This process does not take the place of formal application for any benefit programs, but is needed to assist in determining service eligibility). This information will not be used in a punitive way.**
   - ❒ Under $20,000
   - ❒ $20,000 - $30,000
   - ❒ Over $30,000

7. **Do you own your own home?**
   - ❒ Yes
   - ❒ No

8. **Do you pay out of pocket for any of the following services?**

Service	Out of Pocket Expense? (circle one)	Amount paid out of pocket per month
Transportation	Yes No	$
Day Health Program	Yes No	$
Medications	Yes No	$
Personal Care Attendant	Yes No	$
Home Modifications	Yes No	$
Respite	Yes No	$
Housing	Yes No	$
Meals on Wheels	Yes No	$
Personal Emergency Response System (PERS)	Yes No	$
Homemaker/Home Health Aide	Yes No	$
Other (write in)	Yes No	$

Comments:

SECTION D. CONSUMER REQUEST/REASON FOR ASSISTANCE

Request for Assistance:

❒ **Long Term Supports** (Elder Home Care, Adult Day Health, Personal Care, Home Health, Mental Health, Nursing Facility, PACE, SCO, Supported Living)

For consumers requesting Long Term Supports, please complete Level 2, Long Term Supports

❒ **Educational Support**

For consumers requesting Educational Support, please complete Level 3, Employment Module on page 32.

❒ **Employment Support**

For consumers requesting Employment Support, please complete Level 3, Employment Module on page 32.

❒ **Home Modifications**

For consumers requesting Home Modifications, please complete Level 3, Environmental Assessment Module on page 33.

❒ **Deaf or Hard of Hearing Support**

For consumers requesting Deaf or Hard of Hearing Support, please complete Level 2, Section I. Daily Living Skills on page 10.

❒ **Blind/Visual Impairment Support**

For consumers requesting Blind/Visual Impairment Support, please complete Level 2, Section I. Daily Living Skills on page 10.

❒ **Caregiver/Support Person Support**

For consumers requesting Caregiver/Support Person Support please complete Level 3, Caregiver Stress Module on page 31.

Reason for Assessment:

❒ Service request (need services)
❒ First assessment
❒ Follow-up assessment (for existing program(s))
❒ Significant change in status
❒ Referral
❒ Routine assessment (MDS-HC only)
❒ Discharge assessment (covers last 3 days of service (MDS-HC only)
❒ Discharge tracking only (MDS-HC only)
❒ MDS-HC assessment (*if yes, please complete all of Level 2-Long Term Supports, and Level 3-Assessment Modules, as appropriate*)
❒ Other: _____

9. **Do you currently receive any of the following paid services or supports**?

Service	Number of Days/Week	Number of Hours/Day	Provider
Homemaker/Companion			
Personal Care Attendant			
Home care services			
Visiting nurse services			
Adult day health			
Medicaid waiver			
Meals on Wheels			
Supported Living			
Specialized Support			
Support Services for Veterans			
Group Adult Foster Care			
Employment Services			
Transportation			
PACE (Program for All-Inclusive Care for the Elderly)			
SCO (Senior Care Options)			
Home health/skilled nursing			
Private duty nursing			
Mental health/substance abuse services			
Personal emergency response services (PERS)			

Service	Number of Days/Week	Number of Hours/Day	Provider
Outpatient psychotherapy			
Psychiatric day treatment			
PACT (Program of Assertive Community Treatment)			
Psychotherapy treatment			
Other			
Other			
Other			

10. **If you could have your choice, what kind of help would you want to have? What are your personal goals for receiving assistance?**

Comments:

SECTION E. LEGAL INFORMATION

❒ **Yes, I have a Legal Guardian or Rogers Guardianship Order**

Contact Information:
Name: _____
Address: _____
Town: _____State: _____
Zip Code: _____ Phone: _____

1. **How often do you see your guardian?** _____
2. **What areas of your life does your guardian help you with?**
   - ❒ Health-related issues/concerns
   - ❒ Medications
   - ❒ Financial issues/concerns
   - ❒ Other
3. **Do you find it helpful having a guardian?**
   - ❒ If no, why not? _____
4. **Do you want to talk to someone about alternatives to guardianship? Do you want to talk to someone about having the right to make some decisions yourself?**
   - ❒ Yes
   - ❒ No

❒ **Yes, I have Advanced Medical Directives or Psychiatric Advanced Directives** (paperwork that tells your doctors and /or family what to do if you aren't able to do so yourself)

Who has a copy of that paperwork?
Name: _____
Address: _____
Town: _____State: _____

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	Zip Code: _____ Phone: _____
❒ **Yes, I have a Durable Power of Attorney—Health Care** (a person who makes legal decisions for you regarding your health should you be unable to do so)	**Contact Information:** Name: _____ Address: _____ Town: _____State: _____ Zip Code: _____ Phone: _____

5. **Are you comfortable with this person making decisions about your health care?**
   ❒ Yes
   ❒ No
   If no, why not? _____

6. **If you are not comfortable with this person making decisions about your health care, would you like assistance finding an alternative person to help you?**
   ❒ Yes
   ❒ No

❒ **Yes, I have a Representative Payee or Money Manager** (someone who pays your bills for you and handles your money)	**Contact Information:** Name: _____ Address: _____ Town: _____State: _____ Zip Code: _____ Phone: _____

7. **How often do you see the person who handles your money and pays your bills?**_____

8. **Are you comfortable with this person handling your money and paying your bills?**
   ❒ Yes
   ❒ No
   If no, why not? _____

9. **If you are not comfortable with this person handling your money and paying your bills, would you like help to try and manage your own money?**
   ❒ Yes
   ❒ No

❒ **Yes, I have a Durable Power of Attorney—Finances** (someone who makes legal decisions for you regarding your money should you be unable to do so)	**Contact Information:** Name: _____ Address: _____ Town: _____State: _____ Zip Code: _____ Phone: _____
❒ **Yes, I have a Do Not Resuscitate Order Recorded** (a legal document that says you do not want to be resuscitated/revived should you no longer be able to breath on your own)	**Who has a copy of that paperwork?** Name: _____ Address: _____ Town: _____State: _____ Zip Code: _____ Phone: _____

Comments:

SECTION F. HOUSING AND RESIDENTIAL STATUS

1. **Where are you currently living?**
   - ❒ Private home/apartment with no home care services
   - ❒ Private home/apartment with home care services or supported housing services
   - ❒ Board and care/assisted living/group home
   - ❒ Nursing home
   - ❒ Intermediate care facility
   - ❒ State hospital
   - ❒ Other _____

2. **Who are you currently living with?**
   - ❒ Live alone
   - ❒ Live with spouse only
   - ❒ Live with spouse and others
   - ❒ Live with child (not spouse)
   - ❒ Live with other(s) (not spouse or children)
   - ❒ Live in group setting with non-relative(s) (e.g. nursing home, Intermediate care facility, group home, assisted living)
   - ❒ Live with parent(s)

Comments:

Level 2: Long Term Supports

SECTION G: RISK FACTORS

❒ **Yes, I have a Primary Care Physician** **If you do not have a primary care physician, would you like assistance finding one?** ❒ Yes ❒ No	**Contact Information:** Name: _____ Address: _____ Town: _____State: _____ Zip Code: _____ Phone: _____
❒ **Yes, I have a Specialty Care Physician** **If you do not have a specialty care physician, would you like assistance finding one?** ❒ Yes ❒ No	**Contact Information:** Name: _____ Address: _____ Town: _____State: _____ Zip Code: _____ Phone: _____

1. **Have you seen a dentist or received dental care in the last year?**
   - ❒ Yes
   - ❒ No (*if "No", please complete the Nutritional Risk Module, page 41)*

2. **Have you visited your primary or specialty care physician in the past year?**
   - ❒ Yes
   - ❒ No

3. **How would you rate your overall health in the past 6 months? (This includes your physical, emotional, and mental health.)**
   - ❒ Excellent
   - ❒ Very good
   - ❒ Good
   - ❒ Fair
   - ❒ Poor

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4. **Do you have trouble remembering things (e.g. difficulty remembering the right word, being forgetful)?**

❒ No
❒ Yes (*if "Yes", please complete Level 3, Functional Memory & Cognition Module, page 35*)

5. **Do you have trouble with organizational skills (e.g. making decisions about organizing your day, when to get up or have meals, which clothes to wear or activities to do)?**

❒ No
❒ Yes *(if "Yes", please complete Level 3, Functional Memory & Cognition Module on page 35)*

6. **In the past month have you had difficulty paying attention or focusing on things, been easily distractible, unable to plan or finish tasks or unable to follow directions? Is this a change for you?**

❒ No
❒ Yes *(if "Yes", please complete Level 3, Functional Memory & Cognition Module on page 35)*

7. **Do you have any emotional concerns, worries, or anxiety that are causing stress in your life?**

❒ No
❒ Yes (*if "Yes", please complete Level 3, Mood & Emotional Well-Being Module on page 39)*

8. **Have you heard, seen, or perceived things that other people haven't (e.g. seen things that aren't really there)?**

❒ No
❒ Yes (*if "Yes", please complete Level 3, Mood &Emotional Well-Being Module on page 39)*

9. **Have you had sensory experiences that you can't explain (e.g. felt there are things crawling all over you)?**

❒ No
❒ Yes (*if "Yes", please complete Level 3, Mood &Emotional Well-Being Module on page 39)*

10. **Have you ever seen or talked to anyone professionally for emotional distress?**

❒ No
❒ Yes (*if "Yes", please complete Level 3, Mood & Emotional Well-Being Module on page 39)*

11. **Have you experienced any of the following feelings during the past month?**

❒ Sadness or feeling down in the dumps, like life is not worth living, that nothing matters
❒ Persistent anger with self or others, easily annoyed
❒ Fear of being abandoned, left alone, or a fear of being with others
❒ Worrying a lot about your body functions or your health
❒ Crying a lot more than usual, or felt tearful
❒ Feeling like spending most of your time alone, and not wanting to see other people
❒ A lack of initiative or starting things on your own
(If any of these boxes are checked, please complete Level 3, Mood & Emotional Well-Being Module on page 39)

12. **Have you done any of these things in the past month?**

❒ Threatened, screamed, or cursed at others
❒ Hit, shoved, or physically abused someone else
❒ Injured or seriously thought about self-injury (e.g. by cutting yourself, burning yourself, etc.)
❒ Had temper outbursts, mood swings or quick changes in your emotions, gotten into arguments with others or felt like you couldn't get your emotions under control
(If any of these boxes are checked, please complete Level 3, Mood & Emotional Well-Being Module on page 39)

13. **Have you fallen in the past year?**

❒ No
❒ Once (*if "Yes", please complete Level 3, Falls Module on page 34)*
❒ 2-3 times (*if "Yes", please complete Level 3, Falls Module on page 34)*
❒ 3 or more times (*if "Yes", please complete Level 3, Falls Module on page 34)*

14. **Have you lost or gained 10 pounds unexpectedly in the past 6 months?**

❒ No
❒ Yes (*if "Yes", please complete Level 3, Nutritional Risk Screen Module on page 41)*

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15. **How many meals do you typically eat each day?**
    - ❒ 0-1 meals (*if "Yes", please complete Level 3, Nutritional Risk Screen Module on page 41)*
    - ❒ 2 meals (*if "Yes", please complete Level 3, Nutritional Risk Screen Module on page 41)*
    - ❒ 3 meals
    - ❒ More than 3 meals

16. **What is your current weight?** _____

17. If **you do not know your current weight, have you been weighed at your doctor's office in the past year?**
    ❒ Yes ❒ No If no, why not? _____

Comments:

SECTION H: UNPAID SUPPORTS/CAREGIVER STATUS

1. **Do you have someone who helps you on a regular basis?**
   ❒ No
   ❒ Yes (*if "Yes" is checked, please complete Level 3, Informal Support Module on page 37)*

2. **What is this person's relationship to you?**
   - ❒ Child or child-in-law
   - ❒ Spouse
   - ❒ Parent
   - ❒ Other Relative
   - ❒ Friend/neighbor
   - ❒ Other _____

3. **Does this person live with you?** ❒ Yes ❒ No

Contact Information:

Name: _____

Address: _____

Town: _____State: _____

Zip Code: _____ Phone: _____

4. **Do you have a backup or second person to help you?**
   ❒ No
   ❒ Yes

5. **What is this person's relationship to you?**
   - ❒ Child or child-in-law
   - ❒ Spouse
   - ❒ Parent
   - ❒ Other Relative
   - ❒ Friend/neighbor
   - ❒ Other _____

6. **Does this person live with you?** ❒ Yes ❒ No

Contact Information:

Name: _____

Address: _____

Town: _____State: _____

Zip Code: _____ Phone: _____

7. **Do you feel safe with the people who enter your home?**
   ❒ Yes
   ❒ No (*If "No" is checked, please answer Level 3, Abuse and Neglect Module on page 29)*

8. **Is there anyone who comes to your home that makes you feel uneasy?**
   ❒ Yes
   ❒ No (*If "No" is checked, please answer Level 3, Abuse and Neglect Module on page 29)*

Comments:

SECTION I. DAILY LIVING SKILLS

Vision

1. **Which best describes your ability to see? (Ability to see in adequate light and with glasses or contacts if used):**
   - ❒ Adequate—sees fine detail, including regular print in newspapers/books
   - ❒ Impaired—sees large print, but not regular print in newspapers/books
   - ❒ Moderately impaired—limited vision; not able to see newspaper headlines, but can identify objects
   - ❒ Highly impaired—object identification in question, but appears to follow objects
   - ❒ Severely impaired—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects
   - ❒ Tunnel vision
   - ❒ Legally blind (with the use of assistive devices, e.g. glasses or contacts)

2. **Do you use any kind of assistive devices to help with your vision?**
   - ❒ No
   - ❒ Yes If yes, please indicate what type of device(s) you currently use:
     - ❒ Glasses
     - ❒ Contacts
     - ❒ Hand reader or stand magnifier
     - ❒ Projection devices
     - ❒ Strong convex lenses
     - ❒ Distance magnifiers
     - ❒ Reading rectangle
     - ❒ Seeing eye dog/Guide dog
     - ❒ Other _____

3. **Without the use of your assistive devices, can you do what you need to do on a daily basis?**
   - ❒ Yes
   - ❒ No

4. **Does your assistive device(s) meet your vision needs currently?**
   - ❒ Yes
   - ❒ No If no, why not? _____

5. **Has your vision become worse in the last 3 months, or since your last assessment?**
   - ❒ Yes
   - ❒ No

6. **Have you seen halos or rings around light, curtains over eyes, or flashes of lights?**
   - ❒ Yes
   - ❒ No

Hearing

1. **Which best describes your ability to hear? (With hearing appliance if used):**
   - ❒ Hears adequately—normal talk, TV, phone, doorbell
   - ❒ Minimal difficulty—when not in quiet setting
   - ❒ Hears in special situations only—speaker has to adjust tonal quality and speak directly
   - ❒ Highly impaired—absence of useful hearing

2. **Do you use any kind of assistive device to help with your hearing?**
   - ❒No
   - ❒ Yes If yes, please indicate what type of device:
     - ❒ Assistive listening device
     - ❒ FM sound system

- ❒ Infra-red sound system
- ❒ Audio loop system
- ❒ Hearing aid(s)
- ❒ Cochlear implant(s)
- ❒ TTY telephone
- ❒ Hearing dog
- ❒ Other _____

3. **Without the use of your assistive devices, can you do what you need to do on a daily basis?**
   - ❒ Yes
   - ❒ No
4. **Does your assistive device(s) meet your hearing needs currently?**
   - ❒ Yes
   - ❒ No If no, why not? _____
5. **Has your hearing become worse in the last 3 months, or since your last assessment?**
   - ❒ Yes
   - ❒ No
6. **Do you have difficulty distinguishing different sounds or words? (e.g. consonants or different sounds during speech**)
   - ❒ Yes
   - ❒ No

Communication

1. **Which best describes your ability to communicate? (Expressing information content—however able):**
   - ❒ Understood—expresses ideas without difficulty
   - ❒ Usually understood—difficulty finding words or finishing thoughts but if given time, little or no prompting required
   - ❒ Often understood—difficulty finding words or finishing thoughts, prompting usually required
   - ❒ Sometimes understood—ability is limited to making concrete requests
   - ❒ Rarely/never understood
2. **Which best describes your ability to understand others? (Understands verbal information—however able)**
   - ❒ Understands—clear comprehension
   - ❒ Usually understands—misses some part/intent of message, but comprehends most conversation with little or no prompting
   - ❒ Often understands—misses some part/intent of message, with prompting can often comprehend conversation
   - ❒ Sometimes understands—responds adequately to simple, direct communication
   - ❒ Rarely/never understands
3. **Do you use any type of assistive device to help with communication?**
   - ❒ No
   - ❒ Yes If yes, please indicate what type of device:
     - ❒ Voice recognition software
     - ❒ Alpha Talker
     - ❒ Cheap Talk
     - ❒ Mini Message Mate
     - ❒ Speak Easy
     - ❒ Voice Photo Album
     - ❒ Link-Assistive Device
     - ❒ Bigmak Switch
     - ❒ Other _____
4. **Without the use of your assistive devices, are you able to do what you need to do on a daily basis?**
   - ❒ Yes
   - ❒ No
5. **Do your assistive devices(s) meet your communication needs currently?**
   - ❒ Yes
   - ❒ No If no, why not? _____

6. **Has your ability to communicate (making yourself understood or understanding others) become worse in the last 3 months, or since your last assessment?**
   - ❒ Yes
   - ❒ No

Section I: Instrumental Activities of Daily Living

MEAL PREPARATION:

Definition: How meals are prepared including planning meals, cooking, assembling ingredients, setting out food and utensils. This includes the ability to independently open containers and use kitchen appliances with assistive devices if person uses them. If person is fed via tube feedings or intravenously, treat preparation of the tube feeding as meal preparation and indicate level of help needed.

Coding:

1. Code for functioning in routine activities around the home or in the community during the **LAST 7 DAYS**.
   (a) **IADL Self-Performance Code/Ability Code** (Code for client's performance during LAST 7 DAYS)
   0. INDEPENDENT- did on own
   1. SOME HELP- help some of the time
   2. FULL HELP- performed with help all of the time
   3. BY OTHERS- performed by others
   8. ACTIVITY DID NOT OCCUR

   (b) **IADL Difficulty Code**: How difficult it is (or would it be) for client to do activity on own
   0. NO DIFFICULTY
   1. SOME DIFFICULTY-e.g. needs some help, is very slow, or fatigues
   2. GREAT DIFFICULTY-e.g. little or no involvement in the activity is possible
   3. UNABLE TO PERFORM

2. Indicate whether assistive devices/technology is used and document what specific devices are used.
3. Indicate whether the consumer is able and interested in self-directing activity.
4. Document whether activity is currently an unmet need.
5. Score for overall Performance (0-8) and overall Difficulty (0-3).

Planning meals (Do you plan your meals or decide on the menu? Are you able to do this? How difficult is it or would it be for you to do this?) ❒ Ability (0-8) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	**Cooking (Do you cook your own meals? Are you able to do this? How difficult is it or would it be for you to do this?)** ❒ Ability (0-8) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need
Assembling ingredients (Do you gather the ingredients together? Are you able to do this? How difficult is it or would it be for you to do this?) EXCLUDES SHOPPING ❒ Ability (0-8) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	**Setting out food and utensils (Do you set the table and put the food out? Are you able to do this? How difficult is it or would it be for you to do this?)** ❒ Ability (0-8) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need
❒ Overall Meal Preparation Performance (0-8) **❒ Overall Meal Preparation Difficulty (0-3)**	**Comments:** Include assistive devices if used.

FOR REVIEW PURPOSES ONLY

ORDINARY HOUSEWORK:

Definition: How ordinary work around the house is performed (e.g. doing dishes, dusting, making bed, tidying up, laundry).

Coding:

1. Code for functioning in routine activities around the home or in the community during the **LAST 7 DAYS**.
   (a) **IADL Self-Performance Code/Ability Code** (Code for client's performance during LAST 7 DAYS)
      0. INDEPENDENT- did on own
      1. SOME HELP- help some of the time
      2. FULL HELP- performed with help all of the time
      3. BY OTHERS- performed by others
      8. ACTIVITY DID NOT OCCUR

   (b) **IADL Difficulty Code**: How difficult it is (or would it be) for client to do activity on own
      0. NO DIFFICULTY
      1. SOME DIFFICULTY-e.g. needs some help, is very slow, or fatigues
      2. GREAT DIFFICULTY-e.g. little or no involvement in the activity is possible
      3. UNABLE TO PERFORM

2. Indicate whether assistive devices/technology is used and document what specific devices are used.
3. Indicate whether the consumer is able and interested in self-directing activity.
4. Document whether activity is currently an unmet need.
5. Score for overall Performance (0-8) and overall Difficulty (0-3).

Doing dishes (Do you do your own dishes? Are you able to do this? How difficult is it or would it be for you to do this?) ❒ Ability (0-8) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	**Dusting (Do you dust around your home or apartment? Are you able to do this? How difficult is it or would it be for you to do this?)** ❒ Ability (0-8) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need
Making bed (Do you make your own bed? Are you able to do this? How difficult is it or would it be for you to do this?) ❒ Ability (0-8) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	**Tidying up (Do you tidy up around the house or apartment? Are you able to do this? How difficult is it or would it be for you to do this?)** ❒ Ability (0-8) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need
Laundry (Do you do your own laundry? Are you able to do this? How difficult is it or would it be for you to do this?) ❒ Ability (0-8) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	
❒ Overall Housework Performance (0-8) **❒ Overall Housework Difficulty (0-3)**	**Comments:** Include assistive devices if used.

FOR REVIEW PURPOSES ONLY

MANAGING FINANCES

Definition: How bills are paid, checkbook is balanced, household expenses are balanced, credit card account is monitored, write checks or money orders, exchange currency, handle coins and paperwork.

Coding:

1. Code for functioning in routine activities around the home or in the community during the **LAST 7 DAYS**.
   (a) **IADL Self-Performance Code/Ability Code** (Code for client's performance during LAST 7 DAYS)
      0. INDEPENDENT- did on own
      1. SOME HELP- help some of the time
      2. FULL HELP- performed with help all of the time
      3. BY OTHERS- performed by others
      8. ACTIVITY DID NOT OCCUR

   (b) **IADL Difficulty Code**: How difficult it is (or would it be) for client to do activity on own
      0. NO DIFFICULTY
      1. SOME DIFFICULTY-e.g. needs some help, is very slow, or fatigues
      2. GREAT DIFFICULTY-e.g. little or no involvement in the activity is possible
      3. UNABLE TO PERFORM

2. Indicate whether assistive devices/technology is used and document what specific devices are used.
3. Indicate whether the consumer is able and interested in self-directing activity.
4. Document whether activity is currently an unmet need.
5. Score for overall Performance (0-8) and overall Difficulty (0-3).

How bills are paid (How do you pay your bills? Are you able to do this? How difficult is it or would it be for you to do this?) ❒ Ability (0-8) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	**Checkbook is balanced (How do you balance your checkbook? Are you able to do this? How difficult is it or would it be for you to do this?)** ❒ Ability (0-8) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need
Household expenses are balanced (Do you balance your budget? Are you able to do this? How difficult is it or would it be for you to do this?) ❒ Ability (0-8) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	**Writing checks or money orders (Do you write checks or money orders? Are you able to do this? How difficult is it or would it be for you to do this?)** ❒ Ability (0-8) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need
❒ **Overall Managing Finance Performance (0-8)** ❒ **Overall Managing Finance Difficulty (0-3)**	**Comments:** Include assistive devices if used.

FOR REVIEW PURPOSES ONLY

MANAGING MEDICATIONS

Definition: How medications are managed and the ability to follow prescribed medication regime (e.g. remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)

Coding:

1. Code for functioning in routine activities around the home or in the community during the **LAST 7 DAYS**.
   (a) **IADL Self-Performance Code/Ability Code** (Code for client's performance during LAST 7 DAYS)
      0. INDEPENDENT- did on own
      1. SOME HELP- help some of the time
      2. FULL HELP- performed with help all of the time
      3. BY OTHERS- performed by others
      8. ACTIVITY DID NOT OCCUR

   (b) **IADL Difficulty Code**: How difficult it is (or would it be) for client to do activity on own
      0. NO DIFFICULTY
      1. SOME DIFFICULTY-e.g. needs some help, is very slow, or fatigues
      2. GREAT DIFFICULTY-e.g. little or no involvement in the activity is possible
      3. UNABLE TO PERFORM

2. Indicate whether assistive devices/technology is used and document what specific devices are used.
3. Indicate whether the consumer is able and interested in self-directing activity.
4. Document whether activity is currently an unmet need.
5. Score for overall Performance (0-8) and overall Difficulty (0-3).

Remembering to take medications (Do you remember to take your medications? Are you able to do this? How difficult is it or would it be for you to do this?) ❒ Ability (0-8) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	**Opening bottles (Are you able to open your medication bottles? Are you able to do this? How difficult is it or would it be for you to do this?)** ❒ Ability (0-8) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need
Correct drug dosages (Do you take the correct dosages as prescribed? Are you able to do this? How difficult is it or would it be for you to do this?) ❒ Ability (0-8) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	**Giving injections (Do you give yourself injections? Are you able to do this? How difficult is it or would it be for you to do this?)** ❒ Ability (0-8) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need
Applying ointments (Do you apply your own ointments? Are you able to do this? How difficult is it or would it be for you to do this?) ❒ Ability (0-8) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	
❒ Overall Med Management Performance (0-8) **❒ Overall Med Management Difficulty (0-3)**	**Comments:** Include assistive devices if used.

FOR REVIEW PURPOSES ONLY

PHONE USE

Definition: How telephone calls are made or received (with assistive devices, such as large numbers on telephone, amplification as needed)

Coding:

1. Code for functioning in routine activities around the home or in the community during the **LAST 7 DAYS**.
   (a) **IADL Self-Performance Code/Ability Code** (Code for client's performance during LAST 7 DAYS)
   0. INDEPENDENT- did on own
   1. SOME HELP- help some of the time
   2. FULL HELP- performed with help all of the time
   3. BY OTHERS- performed by others
   8. ACTIVITY DID NOT OCCUR

   (b) **IADL Difficulty Code**: How difficult it is (or would it be) for client to do activity on own
   0. NO DIFFICULTY
   1. SOME DIFFICULTY-e.g. needs some help, is very slow, or fatigues
   2. GREAT DIFFICULTY-e.g. little or no involvement in the activity is possible
   3. UNABLE TO PERFORM

2. Indicate whether assistive devices/technology is used and document what specific devices are used.
3. Indicate whether the consumer is able and interested in self-directing activity.
4. Document whether activity is currently an unmet need.
5. Score for overall Performance (0-8) and overall Difficulty (0-3).

How do you use the telephone? How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed). Are you able to do this? How difficult is it or would it be for you to do this? ❒ Ability (0-8) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	
❒ Overall Phone Use Performance (0-8) **❒ Overall Phone Use Difficulty (0-3)**	**Comments:** Include assistive devices if used.

FOR REVIEW PURPOSES ONLY

SHOPPING

Definition: How shopping is performed for food and household items (e.g. selecting items, paying money, run errands, get around in a store, physically acquire, transport and put away items). EXCLUDES TRANSPORTATION .

Coding:

1. Code for functioning in routine activities around the home or in the community during the **LAST 7 DAYS**.
   (a) **IADL Self-Performance Code/Ability Code** (Code for client's performance during LAST 7 DAYS)
   0. INDEPENDENT- did on own
   1. SOME HELP- help some of the time
   2. FULL HELP- performed with help all of the time
   3. BY OTHERS- performed by others
   8. ACTIVITY DID NOT OCCUR

   (b) **IADL Difficulty Code**: How difficult it is (or would it be) for client to do activity on own
   0. NO DIFFICULTY
   1. SOME DIFFICULTY-e.g. needs some help, is very slow, or fatigues
   2. GREAT DIFFICULTY-e.g. little or no involvement in the activity is possible
   3. UNABLE TO PERFORM

2. Indicate whether assistive devices/technology is used and document what specific devices are used.
3. Indicate whether the consumer is able and interested in self-directing activity.
4. Document whether activity is currently an unmet need.
5. Score for overall Performance (0-8) and overall Difficulty (0-3).

Selecting items (Do you select your own items? Are you able to do this? How difficult is it or would it be for you to do this?) ❒ Ability (0-8) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	**Paying for items (Are you able to manage your money and pay for items you purchase yourself? Are you able to do this? How difficult is it or would it be for you to do this?)** ❒ Ability (0-8) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need
Physically acquire, transport, and put away items (Do you physically shop yourself, bring your purchased items home and put them away? Are you able to do this? How difficult is it or would it be for you to do this?) ❒ Ability (0-8) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	
❒ Overall Shopping Performance (0-8) **❒ Overall Shopping Difficulty (0-3)**	**Comments:** Include assistive devices if used.

FOR REVIEW PURPOSES ONLY

TRANSPORTATION

Definition: How travels by public transportation (e.g. navigates system, paying fare), or arranges other transport, or drives self (including getting out of house, into/out of vehicles).

Coding:

1. Code for functioning in routine activities around the home or in the community during the **LAST 7 DAYS**.
   (a) **IADL Self-Performance Code/Ability Code** (Code for client's performance during LAST 7 DAYS)
   0. INDEPENDENT- did on own
   1. SOME HELP- help some of the time
   2. FULL HELP- performed with help all of the time
   3. BY OTHERS- performed by others
   8. ACTIVITY DID NOT OCCUR

   (b) **IADL Difficulty Code**: How difficult it is (or would it be) for client to do activity on own
   0. NO DIFFICULTY
   1. SOME DIFFICULTY-e.g. needs some help, is very slow, or fatigues
   2. GREAT DIFFICULTY-e.g. little or no involvement in the activity is possible
   3. UNABLE TO PERFORM

2. Indicate whether assistive devices/technology is used and document what specific devices are used.
3. Indicate whether the consumer is able and interested in self-directing activity.
4. Document whether activity is currently an unmet need.
5. Score for overall Performance (0-8) and overall Difficulty (0-3).

Use public transportation including navigating system and paying fares (whether on foot or in wheelchair). Are you able to do this? How difficult is it or would it be for you to do this?) ❒ Ability (0-8) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	**Arrange other transportation. Are you able to do this? How difficult is it or would it be for you to do this?)** ❒ Ability (0-8) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need
Drive self (including ability to get in/out of house and in/out of vehicle whether on foot or in wheelchair) Are you able to do this? How difficult is it or would it be for you to do this?) ❒ Ability (0-8) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	
❒ Overall Transportation Performance (0-8) **❒ Overall Transportation Difficulty (0-3)**	**Comments:** Include assistive devices if used.

FOR REVIEW PURPOSES ONLY

Section I: Activities of Daily Living

General Instructions: The following address the client's physical functioning in routine personal activities of daily life, for example, dressing, eating, etc. during the **LAST 3 DAYS, considering all episodes of these activities.** For clients who performed an activity independently, be sure to determine and record whether others encouraged the activity or were present to supervise or oversee the activity (*Note—For bathing, code for most dependent single episode in **LAST 7 DAYS***).

BATHING

Definition: How takes full body bath/shower. EXCLUDE WASHING BACK AND HAIR. Includes how transfers in/out of tub/shower AND how each part of body is bathes: arms, upper and lower legs, chests, abdomen, perineal area

Coding:
Performance/Ability Code:

0. **INDEPENDENT**—No help, setup, or oversight—OR—Help, setup, oversight provided only 1 or 2 times (with any task or subtask)
1. **SETUP HELP ONLY**—Article or device provided within reach of client 3 or more times
2. **SUPERVISION**—Oversight, encouragement or cueing provided 3 or more times during last 3 days—OR—Supervision (1 ore more times) plus physical assistance provided only 1 or 2 times (for a total of 3 ore more episodes of help or supervision)
3. **LIMITED ASSISTANCE**—Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 ore more times—OR—Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 ore more episodes of physical help)
4. **EXTENSIVE ASSISTANCE**—Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 ore more times:
   --Weight-bearing support---OR---
   --Full performance by another during part (but not all) of last 3 days
5. **MAXIMAL ASSISTANCE**—Client involved and completed less than 50% of subtasks on own (includes 2+ person assist); received weight bearing help or full performance of certain subtasks 3 or more times
6. **TOTAL DEPENDENCE**—Full performance of activity by another
8. **ACTIVITY DID NOT OCCUR** (regardless of ability)
9. **UNABLE TO PERFORM**

ADL Difficulty Code: How difficult it is (or would it be) for client to do activity on own
0. NO DIFFICULTY
1. SOME DIFFICULTY-e.g. needs some help, is very slow, or fatigues
2. GREAT DIFFICULTY-e.g. little or no involvement in the activity is possible
3. UNABLE TO PERFORM

Full body bath or shower. Are you able to do this? How difficult is it or would it be for you to do this? ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	**Sponge bath or shower. Are you able to do this? How difficult is it or would it be for you to do this?** ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need
Transfer in/out of tub/shower. Are you able to do this? How difficult is it or would it be for you to do this? ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	**Bath each body part (arms, upper and lower legs, chest, abdomen area and perineal area). Are you able to do this? How difficult is it or would it be for you to do this?** ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need
❒ Overall Bathing Performance (0-9) **❒ Overall Bathing Difficulty (0-3)**	**Comments:** Include assistive devices if used.

FOR REVIEW PURPOSES ONLY

PERSONAL HYGIENE

Definition: How manages personal hygiene including combing hair, brushing teeth, shaving, applying make-up, washing/drying face and hands. EXCLUDES BATHS AND SHOWERS.

Coding:
Performance/Ability Code:

0. **INDEPENDENT**—No help, setup, or oversight—OR—Help, setup, oversight provided only 1 or 2 times (with any task or subtask)
1. **SETUP HELP ONLY**—Article or device provided within reach of client 3 or more times
2. **SUPERVISION**—Oversight, encouragement or cueing provided 3 or more times during last 3 days—OR—Supervision (1 ore more times) plus physical assistance provided only 1 or 2 times (for a total of 3 ore more episodes of help or supervision)
3. **LIMITED ASSISTANCE**—Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 ore more times—OR—Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 ore more episodes of physical help)
4. **EXTENSIVE ASSISTANCE**—Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 ore more times:
   --Weight-bearing support---OR---
   --Full performance by another during part (but not all) of last 3 days
5. **MAXIMAL ASSISTANCE**—Client involved and completed less than 50% of subtasks on own (includes 2+ person assist); received weight bearing help or full performance of certain subtasks 3 or more times
6. **TOTAL DEPENDENCE**—Full performance of activity by another
8. **ACTIVITY DID NOT OCCUR** (regardless of ability)
9. **UNABLE TO PERFORM**

ADL Difficulty Code: How difficult it is (or would it be) for client to do activity on own
0. NO DIFFICULTY
1. SOME DIFFICULTY-e.g. needs some help, is very slow, or fatigues
2. GREAT DIFFICULTY-e.g. little or no involvement in the activity is possible
3. UNABLE TO PERFORM

Combing hair. Are you able to do this? How difficult is it or would it be for you to do this? ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	**Brushing teeth. Are you able to do this? How difficult is it or would it be for you to do this?** ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need
Shaving. Are you able to do this? How difficult is it or would it be for you to do this? ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	**Applying make-up. Are you able to do this? How difficult is it or would it be for you to do this?** ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need
Washing/drying face and hands. Are you able to do this? How difficult is it or would it be for you to do this? ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	
❒ Overall Hygiene Performance (0-9) **❒ Overall Hygiene Difficulty (0-3)**	**Comments:** Include assistive devices if used.

FOR REVIEW PURPOSES ONLY

DRESSING UPPER BODY

Definition: How dresses and undresses (e.g. street clothes, underwear) above the waist. This includes the ability to put on or take off prostheses, orthotics, pullovers, blouses/shirts and fine motor skills for using buttons, zippers, fasteners, , etc.

Coding:
Performance/Ability Code:

0. **INDEPENDENT**—No help, setup, or oversight—OR—Help, setup, oversight provided only 1 or 2 times (with any task or subtask)
1. **SETUP HELP ONLY**—Article or device provided within reach of client 3 or more times
2. **SUPERVISION**—Oversight, encouragement or cueing provided 3 or more times during last 3 days—OR—Supervision (1 ore more times) plus physical assistance provided only 1 or 2 times (for a total of 3 ore more episodes of help or supervision)
3. **LIMITED ASSISTANCE**—Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 ore more times—OR—Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 ore more episodes of physical help)
4. **EXTENSIVE ASSISTANCE**—Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 ore more times:
   --Weight-bearing support---OR---
   --Full performance by another during part (but not all) of last 3 days
5. **MAXIMAL ASSISTANCE**—Client involved and completed less than 50% of subtasks on own (includes 2+ person assist); received weight bearing help or full performance of certain subtasks 3 or more times
6. **TOTAL DEPENDENCE**—Full performance of activity by another
8. **ACTIVITY DID NOT OCCUR** (regardless of ability)
9. **UNABLE TO PERFORM**

ADL Difficulty Code: How difficult it is (or would it be) for client to do activity on own
0. NO DIFFICULTY
1. SOME DIFFICULTY-e.g. needs some help, is very slow, or fatigues
2. GREAT DIFFICULTY-e.g. little or no involvement in the activity is possible
3. UNABLE TO PERFORM

Dressing above waist. Are you able to do this? How difficult is it or would it be for you to do this? ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	**Putting on and taking off of prosthesis and orthotics. Are you able to do this? How difficult is it or would it be for you to do this?** ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need
Pulling clothes over head. Are you able to do this? How difficult is it or would it be for you to do this? ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	**Using fasteners. Are you able to do this? How difficult is it or would it be for you to do this?** ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need
❒ Overall Upper Body Dressing Performance (0-9) **❒ Overall Upper Body Dressing Difficulty (0-3)**	**Comments:** Include assistive devices if used.

FOR REVIEW PURPOSES ONLY

DRESSING LOWER BODY

Definition: How dresses and undresses (street clothes, underwear) from the waist down. This includes the ability to put on and take off prostheses, orthotics, belts, pants, skirts, shoes, and fine motor skills for using buttons, zippers, or fasteners.

Coding:
Performance/Ability Code:

0. **INDEPENDENT**—No help, setup, or oversight—OR—Help, setup, oversight provided only 1 or 2 times (with any task or subtask)
1. **SETUP HELP ONLY**—Article or device provided within reach of client 3 or more times
2. **SUPERVISION**—Oversight, encouragement or cueing provided 3 or more times during last 3 days—OR—Supervision (1 ore more times) plus physical assistance provided only 1 or 2 times (for a total of 3 ore more episodes of help or supervision)
3. **LIMITED ASSISTANCE**—Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 ore more times—OR—Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 ore more episodes of physical help)
4. **EXTENSIVE ASSISTANCE**—Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 ore more times:
   --Weight-bearing support---OR---
   --Full performance by another during part (but not all) of last 3 days
5. **MAXIMAL ASSISTANCE**—Client involved and completed less than 50% of subtasks on own (includes 2+ person assist); received weight bearing help or full performance of certain subtasks 3 or more times
6. **TOTAL DEPENDENCE**—Full performance of activity by another
8. **ACTIVITY DID NOT OCCUR** (regardless of ability)
9. **UNABLE TO PERFORM**

ADL Difficulty Code: How difficult it is (or would it be) for client to do activity on own
0. NO DIFFICULTY
1. SOME DIFFICULTY-e.g. needs some help, is very slow, or fatigues
2. GREAT DIFFICULTY-e.g. little or no involvement in the activity is possible
3. UNABLE TO PERFORM

Dressing below waist. Are you able to do this? How difficult is it or would it be for you to do this? ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	**Putting on and taking off of prosthesis and orthotics. Are you able to do this? How difficult is it or would it be for you to do this?** ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need
Putting on belts, skirts, pants, shoes. Are you able to do this? How difficult is it or would it be for you to do this? ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	**Using fasteners. Are you able to do this? How difficult is it or would it be for you to do this?** ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need
❒ **Overall Lower Body Dressing Performance (0-9)** ❒ **Overall Lower Body Dressing Difficulty (0-3)**	**Comments:** Include assistive devices if used.

FOR REVIEW PURPOSES ONLY

LOCOMOTION OUTSIDE OF HOME

Definition: How walks or uses wheelchair outside of home to move between locations outside the home. Note: please score an individual's self-sufficiency once in wheelchair.

Coding:
Performance/Ability Code:

0. **INDEPENDENT**—No help, setup, or oversight—OR—Help, setup, oversight provided only 1 or 2 times (with any task or subtask)
1. **SETUP HELP ONLY**—Article or device provided within reach of client 3 or more times
2. **SUPERVISION**—Oversight, encouragement or cueing provided 3 or more times during last 3 days—OR—Supervision (1 ore more times) plus physical assistance provided only 1 or 2 times (for a total of 3 ore more episodes of help or supervision)
3. **LIMITED ASSISTANCE**—Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 ore more times—OR—Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 ore more episodes of physical help)
4. **EXTENSIVE ASSISTANCE**—Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 ore more times:
   --Weight-bearing support---OR---
   --Full performance by another during part (but not all) of last 3 days
5. **MAXIMAL ASSISTANCE**—Client involved and completed less than 50% of subtasks on own (includes 2+ person assist); received weight bearing help or full performance of certain subtasks 3 or more times
6. **TOTAL DEPENDENCE**—Full performance of activity by another
8. **ACTIVITY DID NOT OCCUR** (regardless of ability)
9. **UNABLE TO PERFORM**

ADL Difficulty Code: How difficult it is (or would it be) for client to do activity on own
0. NO DIFFICULTY
1. SOME DIFFICULTY-e.g. needs some help, is very slow, or fatigues
2. GREAT DIFFICULTY-e.g. little or no involvement in the activity is possible
3. UNABLE TO PERFORM

Locomotion outside home (walking or using wheelchair). Are you able to do this? How difficult is it or would it be for you to do this? ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	
❒ **Overall Locomotion Outside Home Performance (0-9)** ❒ **Overall Locomotion Outside Home Difficulty (0-3)**	**Comments:** Include assistive devices if used.

FOR REVIEW PURPOSES ONLY

LOCOMOTION IN HOME

Definition: How walks or uses wheelchair to move between locations inside the home. Note: please score an individual's self-sufficiency once in wheelchair.

Coding:
Performance/Ability Code:

0. **INDEPENDENT**—No help, setup, or oversight—OR—Help, setup, oversight provided only 1 or 2 times (with any task or subtask)
1. **SETUP HELP ONLY**—Article or device provided within reach of client 3 or more times
2. **SUPERVISION**—Oversight, encouragement or cueing provided 3 or more times during last 3 days—OR—Supervision (1 ore more times) plus physical assistance provided only 1 or 2 times (for a total of 3 ore more episodes of help or supervision)
3. **LIMITED ASSISTANCE**—Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 ore more times—OR—Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 ore more episodes of physical help)
4. **EXTENSIVE ASSISTANCE**—Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 ore more times:
   --Weight-bearing support---OR---
   --Full performance by another during part (but not all) of last 3 days
5. **MAXIMAL ASSISTANCE**—Client involved and completed less than 50% of subtasks on own (includes 2+ person assist); received weight bearing help or full performance of certain subtasks 3 or more times
6. **TOTAL DEPENDENCE**—Full performance of activity by another
8. **ACTIVITY DID NOT OCCUR** (regardless of ability)
9. **UNABLE TO PERFORM**

ADL Difficulty Code: How difficult it is (or would it be) for client to do activity on own
0. NO DIFFICULTY
1. SOME DIFFICULTY-e.g. needs some help, is very slow, or fatigues
2. GREAT DIFFICULTY-e.g. little or no involvement in the activity is possible
3. UNABLE TO PERFORM

Locomotion inside home (walking or using wheelchair). Are you able to do this? How difficult is it or would it be for you to do this? ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	
❒ Overall Locomotion In Home Performance (0-9) **❒ Overall Locomotion In Home Difficulty (0-3)**	**Comments:** Include assistive devices if used.

FOR REVIEW PURPOSES ONLY

TRANSFER

Definition: The physical ability to move between surfaces: from bed/chair to wheelchair; walker or standing position; the ability to get in and out of bed or usual sleeping place; the ability to use assisted devices for transfers.

Coding:
Performance/Ability Code:

0. **INDEPENDENT**—No help, setup, or oversight—OR—Help, setup, oversight provided only 1 or 2 times (with any task or subtask)
1. **SETUP HELP ONLY**—Article or device provided within reach of client 3 or more times
2. **SUPERVISION**—Oversight, encouragement or cueing provided 3 or more times during last 3 days—OR—Supervision (1 ore more times) plus physical assistance provided only 1 or 2 times (for a total of 3 ore more episodes of help or supervision)
3. **LIMITED ASSISTANCE**—Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 ore more times—OR—Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 ore more episodes of physical help)
4. **EXTENSIVE ASSISTANCE**—Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 ore more times:
   --Weight-bearing support---OR---
   --Full performance by another during part (but not all) of last 3 days
5. **MAXIMAL ASSISTANCE**—Client involved and completed less than 50% of subtasks on own (includes 2+ person assist); received weight bearing help or full performance of certain subtasks 3 or more times
6. **TOTAL DEPENDENCE**—Full performance of activity by another
8. **ACTIVITY DID NOT OCCUR** (regardless of ability)
9. **UNABLE TO PERFORM**

ADL Difficulty Code: How difficult it is (or would it be) for client to do activity on own
0. NO DIFFICULTY
1. SOME DIFFICULTY-e.g. needs some help, is very slow, or fatigues
2. GREAT DIFFICULTY-e.g. little or no involvement in the activity is possible
3. UNABLE TO PERFORM

Moving to and from bed. Are you able to do this? How difficult is it or would it be for you to do this? ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	**Moving to and from chair. Are you able to do this? How difficult is it or would it be for you to do this?** ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need
Moving to and from wheelchair. Are you able to do this? How difficult is it or would it be for you to do this? ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	**Moving to and from standing position. Are you able to do this? How difficult is it or would it be for you to do this?** ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need
❒ Overall Transfer Performance (0-9) **❒ Overall Transfer Difficulty (0-3)**	**Comments:** Include assistive devices if used.

FOR REVIEW PURPOSES ONLY

TOILET USE

Definition: The ability to use the toilet, commode, bedpan or urinal. This includes transferring on and off the toilet, cleansing of self after using toilet or incontinent episode, changing of apparel or pads, managing any special devices required such as an ostomy or catheter and adjusting clothing.

Coding:
Performance/Ability Code:

0. **INDEPENDENT**—No help, setup, or oversight—OR—Help, setup, oversight provided only 1 or 2 times (with any task or subtask)
1. **SETUP HELP ONLY**—Article or device provided within reach of client 3 or more times
2. **SUPERVISION**—Oversight, encouragement or cueing provided 3 or more times during last 3 days—OR—Supervision (1 ore more times) plus physical assistance provided only 1 or 2 times (for a total of 3 ore more episodes of help or supervision)
3. **LIMITED ASSISTANCE**—Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 ore more times—OR—Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 ore more episodes of physical help)
4. **EXTENSIVE ASSISTANCE**—Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 ore more times:
   --Weight-bearing support---OR---
   --Full performance by another during part (but not all) of last 3 days
5. **MAXIMAL ASSISTANCE**—Client involved and completed less than 50% of subtasks on own (includes 2+ person assist); received weight bearing help or full performance of certain subtasks 3 or more times
6. **TOTAL DEPENDENCE**—Full performance of activity by another
8. **ACTIVITY DID NOT OCCUR** (regardless of ability)
9. **UNABLE TO PERFORM**

ADL Difficulty Code: How difficult it is (or would it be) for client to do activity on own
0. NO DIFFICULTY
1. SOME DIFFICULTY-e.g. needs some help, is very slow, or fatigues
2. GREAT DIFFICULTY-e.g. little or no involvement in the activity is possible
3. UNABLE TO PERFORM

Using toilet, bedpan, urinal, or commode. Are you able to do this? How difficult is it or would it be for you to do this? ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	**Transferring on/off toilet. Are you able to do this? How difficult is it or would it be for you to do this?** ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need
Cleaning self after toilet use or incontinent episode. Are you able to do this? How difficult is it or would it be for you to do this? ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	**Changing of apparel or pads. Are you able to do this? How difficult is it or would it be for you to do this?** ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need
Managing any special devices required such as ostomy or catheter. Are you able to do this? How difficult is it or would it be for you to do this? ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	**Adjusting clothing. . Are you able to do this? How difficult is it or would it be for you to do this?** ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need
❒ Overall Toilet Use Performance (0-9) **❒ Overall Toilet Use Difficulty (0-3)**	**Comments:** Include assistive devices if used.

FOR REVIEW PURPOSES ONLY

MOBILITY IN BED

Definition: The ability to move to and from a lying position, turn from side to side, and position body while in bed.

Coding:
Performance/Ability Code:

0. **INDEPENDENT**—No help, setup, or oversight—OR—Help, setup, oversight provided only 1 or 2 times (with any task or subtask)
1. **SETUP HELP ONLY**—Article or device provided within reach of client 3 or more times
2. **SUPERVISION**—Oversight, encouragement or cueing provided 3 or more times during last 3 days—OR—Supervision (1 ore more times) plus physical assistance provided only 1 or 2 times (for a total of 3 ore more episodes of help or supervision)
3. **LIMITED ASSISTANCE**—Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 ore more times—OR—Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 ore more episodes of physical help)
4. **EXTENSIVE ASSISTANCE**—Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 ore more times:
   --Weight-bearing support---OR---
   --Full performance by another during part (but not all) of last 3 days
5. **MAXIMAL ASSISTANCE**—Client involved and completed less than 50% of subtasks on own (includes 2+ person assist); received weight bearing help or full performance of certain subtasks 3 or more times
6. **TOTAL DEPENDENCE**—Full performance of activity by another
8. **ACTIVITY DID NOT OCCUR** (regardless of ability)
9. **UNABLE TO PERFORM**

ADL Difficulty Code: How difficult it is (or would it be) for client to do activity on own
0. NO DIFFICULTY
1. SOME DIFFICULTY-e.g. needs some help, is very slow, or fatigues
2. GREAT DIFFICULTY-e.g. little or no involvement in the activity is possible
3. UNABLE TO PERFORM

Moving to and from a lying position. Are you able to do this? How difficult is it or would it be for you to do this?	**Turning from side to side. Are you able to do this? How difficult is it or would it be for you to do this?**
❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need
Positioning body while in bed. Are you able to do this? How difficult is it or would it be for you to do this? ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	
❒ Overall Bed Mobility Performance (0-9) **❒ Overall Bed Mobility Difficulty (0-3)**	**Comments:** Include assistive devices if used.

FOR REVIEW PURPOSES ONLY

EATING

Definition: The ability to eat and drink using routine or adaptive utensils. This also includes the ability to cut, chew and swallow food. If a person is fed via tube feedings or intravenously, code the individual's ability to manage feeding self through these methods

Coding:
Performance/Ability Code:

0. **INDEPENDENT**—No help, setup, or oversight—OR—Help, setup, oversight provided only 1 or 2 times (with any task or subtask)
1. **SETUP HELP ONLY**—Article or device provided within reach of client 3 or more times
2. **SUPERVISION**—Oversight, encouragement or cueing provided 3 or more times during last 3 days—OR—Supervision (1 ore more times) plus physical assistance provided only 1 or 2 times (for a total of 3 ore more episodes of help or supervision)
3. **LIMITED ASSISTANCE**—Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 ore more times—OR—Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 ore more episodes of physical help)
4. **EXTENSIVE ASSISTANCE**—Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 ore more times:
   --Weight-bearing support---OR---
   --Full performance by another during part (but not all) of last 3 days
5. **MAXIMAL ASSISTANCE**—Client involved and completed less than 50% of subtasks on own (includes 2+ person assist); received weight bearing help or full performance of certain subtasks 3 or more times
6. **TOTAL DEPENDENCE**—Full performance of activity by another
8. **ACTIVITY DID NOT OCCUR** (regardless of ability)
9. **UNABLE TO PERFORM**

ADL Difficulty Code: How difficult it is (or would it be) for client to do activity on own
0. NO DIFFICULTY
1. SOME DIFFICULTY-e.g. needs some help, is very slow, or fatigues
2. GREAT DIFFICULTY-e.g. little or no involvement in the activity is possible
3. UNABLE TO PERFORM

Cutting food. Are you able to do this? How difficult is it or would it be for you to do this? ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	**Chewing food. Are you able to do this? How difficult is it or would it be for you to do this?** ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need
Swallowing food. Are you able to do this? How difficult is it or would it be for you to do this? ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need	**Using utensils or adaptive utensils. Are you able to do this? How difficult is it or would it be for you to do this?** ❒ Ability (0-9) ❒ Difficulty (0-3) ❒ Assistive Technology/Devices Used ❒ Able and Interested in Self-Directing ❒ Unmet Need
❒ Overall Eating Performance (0-9) **❒ Overall Eating Difficulty (0-3)**	**Comments:** Include assistive devices if used.

Has your ability to complete activities of daily living become worse (i.e. now more impaired in self-performance) in the last 3 months or since your last assessment?
❒ Yes
❒ No

SECTION J. EMPLOYMENT AND COMMUNITY INVOLVEMENT

Employment

1. **Are you employed?**
   - ❒ Yes (*if "Yes", please complete Level 3, Employment Module on page 32*)
   - ❒ No

2. **If you are not employed, do you wish to be employed?**
   - ❒ Yes (*if "Yes", please complete Level 3, Employment Module on page 32*)
   - ❒ No

3. **If you are not currently employed, and wish to be employed, what are the barriers to employment?**
   - ❒ Lack of appropriate job openings
   - ❒ Need for further education and training
   - ❒ Medical issues
   - ❒ Emotional or behavioral issues
   - ❒ Financial issues (impact on benefits)
   - ❒ Transportation
   - ❒ Family expectations
   - ❒ Individual expectations
   - ❒ Public perception/stigma that you are not considered employable
   - ❒ No employment history or large gaps in employment history
   - ❒ Other _____

Community Involvement

4. Do you see your family and friends as much as you would like to?
   - ❒ Yes
   - ❒ No (*if "No", please complete Level 3, Recreation & Community Involvement Module on page 42)*

5. Do you get out and do activities as much as you would like to?
   - ❒ Yes
   - ❒ No (*if "No", please complete Level 3, Recreation & Community Involvement Module on page 42*)

Comments:

FOR REVIEW PURPOSES ONLY

Level 3: Assessment Modules

Please note: These modules are triggered by answers provided by the consumer in previous sections of this assessment.

MODULE A: ABUSE & NEGLECT

This module assesses a person's risk of abuse and neglect. Please note that all assessors are mandatory reporters. Should a person share information about possible abuse and neglect, a referral must be made to the appropriate parties for further investigation.

1. **Has anyone close to you tried to hurt or harm you recently?**
   - ❒ Yes If yes, who?_____
   - ❒ No
2. **Are you afraid of anyone in your family, any of your caregivers or personal care attendants?**
   - ❒ Yes If yes, who? _____
   - ❒ No
3. **Has anyone close to you called you names or put you down or made you feel badly recently?**
   - ❒ Yes If yes, who? _____
   - ❒ No
4. **Does someone in your family, or any of your caregivers or personal care attendants, make you stay in bed or tell you you're sick when you know you're not, or forced you to stay in your home or not allowed you out of the house?**
   - ❒ Yes If yes, who? _____
   - ❒ No
5. **Has anyone tried to force you to do things that you didn't want to do?**
   - ❒ Yes If yes, who? _____
   - ❒ No
6. **Has anyone taken money or property or used services you pay for that belong to you without your permission?**
   - ❒ Yes If yes, who? _____
   - ❒ No
7. **Who makes decisions about your life…...like how you should live or where you should live?**
   - ❒ I make decisions myself
   - ❒ My spouse/partner makes decisions
   - ❒ My children make decisions
   - ❒ My parents make decisions
   - ❒ My caregiver makes decisions. Please state who caregiver is: _____
   - ❒ My personal care attendant/home care aide makes decisions
   - ❒ My legal guardian makes decisions

Comments:

FOR REVIEW PURPOSES ONLY

MODULE B: CAREGIVER/SUPPORT PERSON STRESS

This module is to be completed by a caregiver or support person only based upon specific request. This module measures an individual's risk of caregiver stress, and provides a score indicating the level of risk.

1. **How would you describe your caregiver status?**
   - ❒ I'm unable to continue in caring activities—e.g. decline in my health makes it difficult to continue
   - ❒ I'm not satisfied with the support received from family and friends (e.g. other children of client)
   - ❒ I feel distressed, angry or depressed
   - ❒ None of above

2. **How would you rate your health?**
   - ❒ Excellent
   - ❒ Very good
   - ❒ Good
   - ❒ Fair
   - ❒ Poor

❒ Yes	❒ No	3. Is your sleep disturbed? (e.g. because your loved one is in and out of bed or wanders around at night)
❒ Yes	❒ No	4. Do you find your care giving role inconvenient? (e.g. because helping takes so much time or it's a long drive over to help)
❒ Yes	❒ No	5. Do you find your caregiver role a physical strain? (e.g. because of lifting in and out of a chair; effort or concentration is required)
❒ Yes	❒ No	6. Do you find your caregiver role confining? (e.g. helping restricts free time or cannot go visiting)
❒ Yes	❒ No	7. Have you found you've had to make family adjustments due to your care giving role?? (e.g. because helping has disrupted routine; there has been no privacy)
❒ Yes	❒ No	8. Have you had to make changes in personal plans due to your care giving role? (e.g. had to turn down a job; could not go on vacation)
❒ Yes	❒ No	9. Have you found there have been other demands on your time? (e.g. from other family members)
❒ Yes	❒ No	10. Have you had to make emotional adjustments due to your care giving role? (e.g. because of severe arguments)
❒ Yes	❒ No	11. Have you found some behavior upsetting? (e.g. because of incontinence; your loved one has trouble remembering thinks or he or she accuses people of taking things)
❒ Yes	❒ No	12. Is it upsetting to find that your loved one has changed so much from his/her former self? (e.g. he/she is a different person than he/she used to be)
❒ Yes	❒ No	13. Have you had to make work adjustments due to your care giving role? (e.g. because of having to take time off)
		14. Have you found your role as a caregiver a financial strain?
❒ Yes	❒ No	15. Are you feeling completely overwhelmed? (e.g. because of worry about my loved one; concerns about how
❒ Yes	❒ No	you will manage)

Total Score: Count "Yes" responses. Any positive answer may indicate a need for intervention in that area. A score of "7" or higher indicates a high level of stress.

Comments:

FOR REVIEW PURPOSES ONLY

MODULE C: EMPLOYMENT

This module assesses a person's interest in obtaining employment, employment history, satisfaction with employment and special needs and accommodations necessary to obtain employment. A referral to an employment specialist, Independent Living Center or other employment agency may be necessary to fully realize a person's potential and/or needs.

1. **If you are currently employed, what is your current job?**

2. **Is this job a paid or non-paid position?**
   ❒ Paid
   ❒ Non-paid
3. **How long have you been employed at this job?**_____
4. **Is this job:** ❒ Full-Time ❒ Part-Time
5. **Do you require reasonable accommodations on the job?**
   ❒ Yes
   ❒ No
6. **If you require reasonable accommodations, what are the accommodations you require?**
7. **Do you require any other support services on the job?**
   ❒ Yes
   ❒ No
8. **If you require other support services, what are the support services you require (for example, do you require a job coach)?**
9. **Have you been employed in the past 5 years?**
   ❒ Yes
   ❒ No
10. **If you have not been employed in the past 5 years, what was the last job you held?**
11. **Are you satisfied with your job?**
    ❒ Yes
    ❒ No
12. **If you are not satisfied with your job, what would you change about it?**
13. **Why did you leave this job?**
14. **Have you ever received an employment evaluation or employment counseling?**
    ❒ Yes
    ❒ No
15. **If you have received an employment evaluation or counseling, when and where was this evaluation conducted?**
    Year: _____ Location: _____
16. **If you have received an employment evaluation or counseling, what were the recommendations?**
17. **Would you like the opportunity to receive additional job skills and/or employment training?**
    ❒ Benefits counseling (e.g. understanding benefit of income on unearned income, learning about the Ticket to Work program)
    ❒ Peer Mentoring (e.g. discussing your disability, learning about recreational activities)
    ❒ Assessment of job skills
    ❒ Skills training (e.g., how to fill out applications, self-advocate, community mobility, gain daily living skills)
    ❒ Your rights under the Americans with Disabilities Act (ADA)

Comments:

FOR REVIEW PURPOSES ONLY

MODULE D: ENVIRONMENTAL ASSESSMENT

This module assesses a person's home environment including home safety, accessibility, need for home modifications, sanitation, and hazards. The information provided should assist in identifying problem areas in the home environment, leading to a problem list and referral(s) to appropriate service providers if necessary.

❒ Yes	❒ No	1. Could you physically get out of your home or apartment building quickly in case of emergency?
❒Yes	❒ No	2. Do you have an emergency exit plan in case of fire or other emergency?
❒ Yes	❒ No	3. Do you have your own access in and out of your home or apartment?
❒ Yes	❒ No	4. Do you have an emergency kit including flashlight, candles, water, in case of a power outage?
❒ Yes	❒ No	5. Do you have emergency phone numbers listed by your phone?
❒ Yes	❒ No	6. Do you feel <u>unsafe</u> in your home or apartment (e.g. fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in the street)?
❒ Yes	❒ No	7. Can you get up and down the stairs without help?
❒ Yes	❒ No	8. Are the doorways in and out of your home or apartment well-lit?
❒ Yes	❒ No	9. Are there any areas of your home or apartment that even with lights on are too dark to see?
❒ Yes	❒ No	10. Are there any obstacles in your home or apartment that get in your way when you are going from one room to another? (e.g. lamps, extension or phone cords, papers, furniture)
❒ Yes	❒ No	11. Do you pile newspapers, magazines, boxes, or other paper materials in your home or apartment?
❒ Yes	❒ No	12. Do your carpets lie flat?
❒ Yes	❒ No	13. Do your small rugs and runners stay put (don't slide or roll up) when you push them with your foot, or use them with a wheelchair, walker or other mobility aid?
❒ Yes	❒ No	14. Are your stove controls easy to see and use?
❒ Yes	❒ No	15. Is there anything in your home or apartment that you can't reach without help?
❒ Yes	❒ No	16. Do you have a working smoke detector on each floor of your home or apartment?
❒ Yes	❒ No	17. Do you have a working fire extinguisher located near your stove?
❒ Yes	❒ No	18. Do have <u>inadequate</u> heating and cooling (e.g. too hot in summer, too cold in winter)?
❒ Yes	❒ No	19. Are your stair rails and banisters in good repair?
❒ Yes	❒ No	20. Are all steps in good repair (not loose, broken, missing or worn in places)?
❒ Yes	❒ No	21. Does your home have clean, drinkable water?
❒ Yes	❒ No	22. Does your refrigerator work properly to store food?
❒ Yes	❒ No	23. Does your home or apartment have problems with insects or rodents?
❒ Yes	❒ No	24. Does your shower or tub have a non-skid surface: mat, decals, or abrasive backing?
❒ Yes	❒ No	25. Does the tub/shower have a sturdy grab bar (not towel rack)?
❒ Yes	❒ No	26. Is toilet easy for you to get up and down on?
❒ Yes	❒ No	27. Are there other hazards or unsafe areas in or around your home not mentioned in this checklist that you are concerned about? If so, please describe:

Comments:

FOR REVIEW PURPOSES ONLY

MODULE E: FALLS

This module assesses a person's history of and risk for repeated falls. Information learned from this module should assist in identifying possible problem areas that need to be addressed in order to reduce an individual's risk of falls. Identified problem areas should become part of a service plan.

❒ Yes	❒ No	1. Do you have a history of any falls in the previous year? If yes, how many falls? _____ 2. If you have fallen one or more times in the past year, what caused the fall(s)? _____ _____ _____ _____ _____
❒ Yes	❒ No	3. Are you taking four or more medications per day?
❒ Yes	❒ No	4. Are you taking any narcotics or muscle relaxants, anti-psychotics or mood stabilizers?
❒ Yes	❒ No	5. Do you consume more than one alcoholic drink a day?
❒ Yes	❒ No	6. Do you have a diagnosis of any neurological, neuromuscular or orthopedic problems?
❒ Yes	❒ No	7. Do you get dizzy when you stand up quickly?
❒ Yes	❒ No	8. Are you unsteady on your feet, do you shuffle or take uneven steps, with or without the use of an assistive device?
❒ Yes	❒ No	9. Do you have any problems with your balance (need to hold on to furniture, require a stick, walker, or wheelchair)?
❒ Yes	❒ No	10. Do you have problems with your eyesight or depth perception?
❒ Yes	❒ No	11. Are you able to rise from a chair of knee height?
❒ Yes	❒ No	12. Do you limit going outdoors due to fear of falling (e.g. stop using bus, go out only with others)

Comments:

MODULE F: FUNCTIONAL MEMORY & COGNITION

This module assesses a person's functional memory and cognition, identifying problem areas a person may have related to Alzheimer's disease or related dementias, traumatic brain injury, transient ischemic attacks (TIAs), and other conditions. Information learned from this module should assist in identifying where an individual may be having trouble. Referral for further evaluation by a licensed professional may be necessary.

Please note: It may not be possible to rely on consumer self-reporting only. It may be necessary to rely on a surrogate decision-maker or support person to answer the questions. Assessor observation may also be necessary.

1. **In the last three months (or since your last assessment if less than three months), have you experienced a worsening in your decision-making ability or have you felt confused when you have to make decisions?**
   - ❒ No
   - ❒ Yes

2. **Do you ever need help or reminders to organize your day? (e.g. Does anyone remind you to get up, go to appointments, eat, dress, or take your medications)?**
   - ❒ Independent—decisions consistent/reasonable/safe
   - ❒ Modified independence—some difficulty in new situations only
   - ❒ Minimally impaired—in specific situations, decisions become poor or unsafe and cues/supervisions necessary at those times
   - ❒ Moderately impaired—Decisions consistently poor or unsafe, cues/supervision required at all times
   - ❒ Severely impaired—Never/rarely make decisions

3. **Do you ever forget what someone just said to you? Do you forget what you were going to do or say?**
   - ❒ Short-term memory is OK --seems/appears to recall after 5 minutes)
   - ❒ Short-term memory is a problem

4. **Do you ever start to do something and then forget what comes next?**
   - ❒ Procedural memory OK--can perform all or almost all steps in a multitask sequence without cues for initiation
   - ❒ Procedural memory is a problem

5. **Do you ever go out of your home and forget where you are or where you are going?**
   - ❒ No
   - ❒ Yes

6. **In the last week, have you noticed any changes in your ability to remember things? Have other people had trouble understanding what you were saying? Have you had trouble paying attention to what other people are saying? Have you had trouble paying attention to what you were doing?**
   - ❒ No
   - ❒ Yes

7. **Do you ever feel scared or worried because you have forgotten where you are? Or what you were doing? Or what you were supposed to do? When this happens, do you feel scared? Do you get mad?**
   - ❒ No
   - ❒ Yes

8. **Do you know what the current year is**?_____

9. **Do you know what the current season is**?_____

10. **Do you know what the current day is**?_____

11. **Do you know what the current month is**?_____

12. **Do you know what state we are in**?_____**What city we are in**?_____

13. **If you're in a hospital, what hospital you are in**? _____

14. **Do you know what street you live on**?_____

15. **Can you repeat these three objects after me? APPLE? PENNY? TABLE?**
   - ❒ Yes
   - ❒ No

16. **Can you spell the following word backwards? WORLD (D-L-R-O-W)**
    - ❒ Yes
    - ❒ No
17. **Can you repeat the following phrase: "No ifs, ands or buts"?**
    - ❒ Yes
    - ❒ No
18. C**an you recall the three objects I asked you to say before? (APPLE, PENNY, TABLE)**
    - ❒ Yes
    - ❒ No
19. **Can you identify the following objects? (Show a watch and pencil)**
    - ❒ Yes
    - ❒ No
20. **If you want to move a piece of heavy furniture, what do you do?**
    - ❒ Ask for help
    - ❒ Try to move it myself even though it is too heavy
    - ❒ Don't bother
21. **If you want to see your friends more often, what do you do?**
    - ❒ Call my friend and make plans
    - ❒ Call my friend and complain that s/he hasn't called me
    - ❒ Don't do anything (Accept the situation as it is)
22. **If a store clerk refuses to make an exchange for something you've returned, what do you do?**
    - ❒ Ask for the manager
    - ❒ Complain loudly
    - ❒ Take the item home

Comments:

FOR REVIEW PURPOSES ONLY

MODULE G: INFORMAL SUPPORT

This module assesses a person's level and type of informal support received and from whom. It also assesses a person's preference for paid versus unpaid support.

1. **What kind of help does your caregiver/support person provide?**
   - ❒ Advice or emotional support
   - ❒ Help with instrumental activities of daily living (IADL support such as preparing meals, answering telephone, shopping)
   - ❒ Help with activities of daily living (ADL support such as bathing, dressing, going to the bathroom)
   - ❒ Environmental support (housing, home maintenance)
   - ❒ Psychosocial support (socialization, companionship, recreation)
   - ❒ Advocates or facilitates participation in health care
   - ❒ Financial agent, conservator, or power of attorney

2. **If needed, is your support person or caregiver willing (and able) to increase help in the following areas?**

   Advice or emotional support
   - ❒ more than 2 hours
   - ❒ 1-2 hours per day
   - ❒ no

   IADL care
   - ❒ more than 2 hours
   - ❒ 1-2 hours per day
   - ❒ no

   ADL care
   - ❒ more than 2 hours
   - ❒ 1-2 hours per day
   - ❒ no

3. **Do you prefer to have a paid employee provide assistance with your daily activities, or do you prefer to have your support person/caregiver provide assistance?**
   - ❒ I would like to have a paid employee instead of my informal support person/caregiver
   - ❒ I would like to have my informal support person/caregiver provide assistance

4. **Does your support person/caregiver have other responsibilities (such as work or other family obligations), physical conditions or health problems that would make it difficult for him or her to help you?**
   - ❒ No
   - ❒ Yes If yes, please explain: _____

   _____

5. **Has your support person/caregiver expressed the need for relief?**
   - ❒ Yes If yes, please explain: _____

   _____

Comments:

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MODULE H: MEDICATION MANAGEMENT

This module assesses a person's ability to manage his or her medications, knowledge of his or her medication regimen, risk of poly pharmacy problems, side effects, and overall compliance.

1. **Do you understand how to take your medication(s)?**
   - ❒ Yes
   - ❒ No

2. **Do you take your medication as prescribed?**
   - ❒ Yes
   - ❒ No *If no, please answer why not:*
     - ❒ I'm concerned about reactions and side effects of my medication(s)
     - ❒ High blood pressure
     - ❒ Lack of energy
     - ❒ Makes me feel sick
     - ❒ I'm unable to afford my medications
     - ❒ I'm unable to get to the pharmacy to pick up my medications
     - ❒ I feel fine and don't think I need my medication anymore
     - ❒ I forget to take them
     - ❒ Don't trust your prescriber
     - ❒ Other _____

3. **Do you understand what your medications are for, their possible side effects, and how they may interact with one another?**
   - ❒ Yes
   - ❒ No

4. **Do you have a list of all of your medications?**
   - ❒ Yes
   - ❒ No

5. **If yes, where do you keep your medication list?** _____

6. **Do you have any medication allergies?**
   - ❒ Yes
   - ❒ No

7. **If you have medication allergies, are your medication allergies documented on your medication list?**
   - ❒ Yes
   - ❒ No

8. **If you have an allergy, do you wear a medication alert bracelet?**
   - ❒ Yes
   - ❒ No

Comments:

MODULE I: MOOD & EMOTIONAL WELL-BEING

This module assesses a person's overall mood and emotional health, including risk of depression. It may be necessary to refer to a licensed professional for a more in-depth evaluation. Please note risks and problem areas and refer as appropriate. It may be necessary to rely on the use of a surrogate decision-maker, support person or assessor observation to complete the answers in this module.

General Instructions: Please indicate whether you have felt any of the following feelings in the past 3 months:

1. ❒ A feeling of sadness or being depressed, that life is not worth living, that nothing matters, that you are of no use to anyone or would rather be dead.
2. ❒ A persistent anger with your self or others—e.g. easily annoyed, anger at the care you receive
3. ❒ Fearful (e.g. worried about being with others, worried that nobody cares and everyone has left me)
4. ❒ Worried about my health and body. Calling my doctor a lot but she/he can't find anything wrong.
5. ❒ Anxious, very concerned or need reassurance regarding your schedule, meals, laundry, clothing, relationship issues
6. ❒ Find myself grimacing, making faces, squinting, sighing
7. ❒ Recurrent crying, tearfulness
8. ❒ Withdrawing yourself from activities of interest—e.g. no interest in long standing activities or being with your family or friends
9. ❒ Reduced social interaction

10. **In the past three months, or since your last assessment if less than three months, has your mood become worse?**
    ❒ No
    ❒ Yes

Please indicate, either through self-report, use of a surrogate decision-maker, or assessor observation, whether any of the following behaviors occurred in the last three days:

11. **Have you wandered lately—moved with no rational purpose, seemingly oblivious to your needs or safety?**
    ❒ Yes
    ❒ No
    If yes, is this behavior risky for the client ❒ Yes ❒ No
    If yes, is this behavior risky for others? ❒ Yes ❒ No
    If behavior is risky, is this behavior easily altered? ❒ Yes ❒ No
12. **Have you ever been verbally abusive, such as threatened, screamed or cursed at others?**
    ❒ Yes
    ❒ No
    If yes, is this behavior risky for the client? ❒ Yes ❒ No
    If yes, is this behavior risky for others? ❒ Yes ❒ No
    If behavior is risky, is this behavior easily altered?❒ Yes ❒ No
13. **Do you engage in any of these following behaviors: (make disruptive sounds, noisiness, screaming, self-abusive acts such as cutting, burning, head banging, sexual behavior or disrobing in public, smears/throws food/feces, rummaging, repetitive behavior, getting up early and causing disruption)?**
    ❒ Yes
    ❒ No
    If yes, is this behavior risky for the client? ❒ Yes ❒ No
    If yes, is this behavior risky for others? ❒ Yes ❒ No
    If behavior is risky, is this behavior easily altered? ❒ Yes ❒ No
14. **Have you ever resisted care—resisted taking medications/injections, assistance with your daily activities, eating, or changing position?**
    ❒ Yes
    ❒ No
    If yes, is this behavior risky for the client? ❒ Yes ❒ No
    If yes, is this behavior risky for others? ❒ Yes ❒ No
    If behavior is risky, is this behavior easily altered? ❒ Yes ❒ No

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15. **Have these behaviors become worse or less tolerated by family as compared to three months ago, or since the last assessment if less than three months?**
    - ❒ Yes
    - ❒ No

Comments:

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MODULE J: NUTRITIONAL RISK SCREEN

This module assesses a person's overall nutritional risk. Please total the answers according to the score chart below and identify overall risk.

❒ Yes	❒ No	1. Do you have illness that has changed the amount or kind of food you have eaten in the last several weeks?
❒ Yes	❒ No	2. Do you eat fewer than two meals a day?
❒ Yes	❒ No	3. Do you eat few fruits, vegetables, or milk products?
❒ Yes	❒ No	4. Do you take three or more drinks of alcohol a day?
❒ Yes	❒ No	5. Do you have a tooth or mouth problem that makes eating difficult?
❒ Yes	❒ No	6. Do you not have enough money to buy food?
❒ Yes	❒ No	7. Do you eat alone most of the time?
❒ Yes	❒ No	8. Do you take three or more drugs, prescription or over the counter, each day?
❒ Yes	❒ No	9. Are you not able to physically shop for food?
❒ Yes	❒ No	10. Are you not able to prepare food?
❒ Yes	❒ No	11. Are you not able to feed yourself?

Scoring: Total all "Yes" or positive answers. Each "Yes" answer equals 1 point, with the exception of 9-11, with each "Yes" answer equaling 1/3 point.

Nutritional Risk Scores:
0 - 2 = Low risk
3 - 5 = Moderate risk
6 or more = High risk

Comments:

MODULE K: RECREATION & COMMUNITY INVOLVEMENT

This module assesses a person's experience with and interest in recreation and community involvement.

1. **Have you ever participated in any volunteer activities in your community?**
   - ❒ Yes
   - ❒ No
2. **Do you still participate in volunteer activities in your community?**
   - ❒ Yes
   - ❒ No

   If no, why did you stop volunteering?

3. **If you do participate in volunteer activities, what are these activities?**

4. **If you do not participate in volunteer or recreational/leisure activities, why not?**

5. **If you do not participate in volunteer or recreational or leisure activities, are you interested in obtaining information about what activities might be available in your community?**
   - ❒ Yes
   - ❒ No
6. **What is your favorite recreational/leisure activities (e.g. things you like to do in your free time—recreational activities that you like to be involved in that are not work-related)?**
   - a. _____
   - b. _____
   - c. _____
   - d. _____
   - e. _____

Comments:

FOR REVIEW PURPOSES ONLY

MODULE L: TRANSPORTATION

This module assesses a person's need for transportation and type of transportation used.

1. **What are your transportation needs?**

2. **Do you require any special accommodations?**
   - ❒ No
   - ❒ Yes Please describe:

3. **Are you able to get to where you need to go?**
   - ❒ Yes
   - ❒ No

4. **What form(s) of transportation do you use currently?**
   - ❒ Drive own care or vehicle
   - ❒ Bus
   - ❒ Subway
   - ❒ Taxi
   - ❒ Shuttle
   - ❒ Paratransit
   - ❒ Family (paid or not paid)
   - ❒ Friend (paid or not paid)
   - ❒ Ambulance van car
   - ❒ Other Please describe:

5. Do you require any assistive devices or vehicular modifications in order to drive?
   - ❒ No
   - ❒ Yes Please describe:

Comments:

FOR REVIEW PURPOSES ONLY

MODULE M: MDS-HOME CARE

This module includes the balance of the MDS-HC questions required by the State for clinical eligibility and comprehensive assessment of person's seeking specific state-funded services including the Medicaid waiver program, Senior Care Options program, and the Program For All-Inclusive Care for the Elderly (PACE).

Questions contained in this module may benefit certain persons seeking services that are not applying for these state-funded programs. Please review and use as necessary.

Assessment Reference Date: _____
Month/Day/Year

Date Case Opened/Reopened : _____
3. Month/Day/Year

Reason for Referral:

- ❒ Post hospital care
- ❒ Community chronic care
- ❒ Home placement screen
- ❒ Eligibility for home care
- ❒ Day care
- ❒ Other _____

Goals of Care: Code for client/family understanding of goals of care

Understanding

❒ Skilled nursing treatments	❒ Yes	❒ No
❒ Monitoring to avoid clinical complications	❒ Yes	❒ No
❒ Rehabilitation	❒ Yes	❒ No
❒ Client/family education	❒ Yes	❒ No
❒ Family respite	❒ Yes	❒ No
❒ Palliative care	❒ Yes	❒ No

Time since last hospital stay. Time since discharge from last in-patient setting (Code for most recent instance in last 180 days).

- ❒ No hospitalization within 180 days
- ❒ Within last week
- ❒ Within 8-14 days
- ❒ Within 15 – 30 days
- ❒ More than 30 days ago

Prior NH placement. Resided in a nursing home at any time during 5 years prior to case opening.

- ❒ Yes
- ❒ No

Social Functioning

1. **Involvement. At ease interacting with others (e.g. likes to spend time with others)**
   - ❒ At ease
   - ❒ Not at ease
2. **Change in Social Activities. As compared to 90 days ago (or since last assessment if less than 90 days ago), decline in the client's level of participation in social, religious, occupational or other preferred activities. If there was a decline, client distressed by this fact.**
   - ❒ No decline
   - ❒ Decline, not distressed
   - ❒ Decline, distressed
3. **Isolation**
   a. Length of time client is alone during the day (morning and afternoon).
      - ❒ Never or hardly ever
      - ❒ About one hour
      - ❒ Long periods of time—e.g. all morning
      - ❒ All of the time

   b. Client says or indicates that he/she feels lonely
      - ❒ No
      - ❒ Yes
4. **Extent of Informal Help.** For instrumental and personal activities of daily living received over the last 7 days, indicate extent of help from family, friends, and neighbors.
   a. Sum of time across five weekdays (in hours) _____
   b. Sum of time across two weekend days (in hours) _____

5. **Primary Modes of Locomotion**
   a. Indoors
      ❒ No assistive device
      ❒ Cane
      ❒ Walker/crutch
      ❒ Scooter (e.g. Amigo)
      ❒ Wheelchair
      ❒ Activity did not occur

6. **Stair Climbing**. In the last 3 days, how client went up and down stairs (e.g. single or multiple steps, using handrail as needed).
      ❒ Up and down stairs without help
      ❒ Up and down stairs with help
      ❒ Not go up and down stairs

7. **Stamina**
   a. In a typical week, during the last 30 days (or since last assessment), code the number of days client usually went out of the house or building in which client lives (no matter how short a time period).
      ❒ Every day
      ❒ 2-6 days a week
      ❒ 1 day a week
      ❒ no days
   b. Hours of physical activities in the last 3 days (e.g. walking, cleaning house, exercise)
      ❒ Two ore more hours
      ❒ Less than two hours

8. **Functional Potential**
      ❒ Client believes he/she is capable of increased functional independence (ADL, IADL, mobility)
      ❒ Caregivers believe client is capable of increased functional independence (ADL, IADL, mobility)
      ❒ Good prospects of recovery from current disease or conditions, improved health status expected
      ❒ None of above

Continence

9. **Bladder Continence**
   a. In last 7 days control of urinary bladder function (with appliances such as catheters or incontinence program employed) [Note—if dribbles, volume insufficient to soak through underpants]
      ❒ Continent—Complete control; does not use any type of catheter or other urinary collection device
      ❒ Continent with catheter—Complete control with use of any type of catheter or urinary collection device that does not leak urine
      ❒ Usually continent—Incontinent episodes once a week or less
      ❒ Occasionally incontinent—Incontinent episodes 2 or more times a week but not daily
      ❒ Frequently incontinent—Tends to be incontinent daily, but some control present
      ❒ Incontinent—Inadequate control, multiple daily episodes
      ❒ Did not occur—No urine output from bladder

   b. Worsening of bladder incontinence as compared to status 90 days ago (or since last assessment if less than 90 days)
      ❒ No
      ❒ Yes

10. **Bladder Devices** (check all that apply in last 7 days)
      ❒ Use of pads or briefs to protect against wetness
      ❒ Use of an indwelling urinary catheter
      ❒ None of above

11. **Bowel Continence**
   a. In last 7 days, control of bowel movement (with appliance or bowel continence program if employed)
      ❒ Continent—Complete control; does not use ostomy device
      ❒ Continent with ostomy—Complete control with use of ostomy device that does not leak stool
      ❒ Usually continent—Bowel incontinent episodes less than weekly
      ❒ Occasionally incontinent—Bowel incontinent episode once a week
      ❒ Frequently incontinent—Bowel incontinent episodes 2-3 times a week
      ❒ Incontinent—Bowel incontinent all (or almost all) of the time
      ❒ Did not occur—No bowel movement during entire 7 day assessment period

Disease Diagnosis

Disease/infection that doctor has indicated is present and affects client's status, requires treatment, or symptom management. Also include if disease is monitored by a home care professional or is the reason for a hospitalization in last 90 days (or since last assessment if less than 90 days).

Blank = Not present
1 = Present-not subjected to focused treatment or monitoring by home care professional
2 = Present-monitored or treated by home care professional
[if no disease in list, check None of Above]

1. *Diseases*
   Heart/Circulation
   ❒ Cerebrovascular accident (stroke)
   ❒ Congestive heart failure
   ❒ Coronary artery disease
   ❒ Hypertension
   ❒ Irregularly irregular pulse
   Neurological
   ❒ Alzheimer's
   ❒ Dementia other than Alzheimer's disease
   ❒ Head trauma
   ❒ Hemiplegia/hemiparesis
   ❒ Multiple sclerosis
   ❒ Parkinsonism
   Musculoskeletal
   ❒ Arthritis
   ❒ Hip fracture
   ❒ Other fractures (e.g. wrist, vertebrae)
   ❒ Osteoporosis
   Senses
   ❒ Cataract
   ❒ Glaucoma
   Psychatric/Mood
   ❒ Any psychiatric diagnosis
   Infections
   ❒ HIV infection
   ❒ Pneumonia
   ❒ Tuberculosis
   ❒ Urinary tract infection (in last 30 days)
   Other Diseases
   ❒ Cancer—(in past 5 years) not including skin cancer
   ❒ Diabetes
   ❒Emphysema/COPD/asthma
   ❒ Renal failure
   ❒ Thyroid disease (hyper or hypo)
   ❒ None of above

2. **Other current or more detailed diagnoses and ICD-9 codes**
   a. _____
   b. _____
   c. _____
   d. _____

Health Conditions and Preventive Health Measures

1. **Preventive Health (past 2 years).** Check all that apply—in past 2 years.
   ❒ Blood pressure measured
   ❒ Received influenza vaccination
   ❒ Test for blood in stool or screening endoscopy
   ❒ If female: received breast examination or mammography
   ❒ None of above

2. **Problem Conditions Present on 2 or More Days** (check all that were present on at least 2 of the last 3 days)
   - ❒ Diarrhea
   - ❒ Difficulty urinating or urinating 3 ore more times a night
   - ❒ Fever
   - ❒ Loss of appetite
   - ❒ Vomiting
   - ❒ None of above

3. **Problem Condition** (check all present at any point during last 3 days)
   Physical Health
   - ❒ Chest pain/pressure at rest or on exertion
   - ❒ No bowel movement in 3 days
   - ❒ Dizziness or lightheadedness
   - ❒ Edema
   - ❒ Shortness of breath

   Mental Health
   - ❒ Delusions
   - ❒ Hallucinations
   - ❒ None of above

4. **Pain**
   a. **Frequency with which client complains or shows evidence of pain**
      - ❒ No pain (score b-e as 0)
      - ❒ Less than daily
      - ❒ Daily—one period
      - ❒ Daily-multiple periods (e.g. morning and evening)

   b. **Intensity of pain**
      - ❒ No pain
      - ❒ Mild
      - ❒ Moderate
      - ❒ Severe
      - ❒ Times when pain is horrible or excruciating

   c. **From client's point of view, pain intensity disrupts usual activities**
      - ❒ No
      - ❒ Yes

   d. **Character of pain**
      - ❒ No pain
      - ❒ Localized—single site
      - ❒Multiple sites

   e. **From client's point of view, medications adequately control pain**
      - ❒ Yes or no pain
      - ❒ Medications do not adequately control pain
      - ❒ Pain present, medication not taken

5. **Lifestyle (Drinking/Smoking)**
   b. **In the last 90 days (or since last assessment if less than 90 days), client felt the need or was told by others to cut down on drinking, or others were concerned with client's drinking**
      - ❒ Yes
      - ❒ No

   c. **In the last 90 days (or since last assessment if less than 90 days), client had to have a drink first thing in the morning to steady nerves (i.e., and "eye opener") or has been in trouble because of drinking**
      - ❒ Yes
      - ❒ No

   d. **Smoked or chewed tobacco daily**
      - ❒ Yes
      - ❒ No

6. **Health Status Indicators** (check all that apply)
   - ❒ Client feels he/she has poor health (when asked)
   - ❒ Have conditions or diseases that make cognition, ADL, mood, or behavior patterns unstable fluctuations, recarious, or deteriorating)

❒Experiencing a flare-up of a recurrent or chronic pain
❒ Treatments changed in last 30 days (or since last assessment if less than 30 days) because of a new acute episode or condition
❒ Prognosis of less than six months to live—e.g. physician has told client or client's family that client has end-stage disease
❒ None of above

7. **Other Status Indicators** (check all that apply)
❒ Fearful of a family member or caregiver
❒ Unusually poor hygiene
❒ Unexplained injuries, broken bones, or burns
❒ Neglected, abused, or mistreated
❒ Physically restrained (e.g., limbs restrained, used bed rails)
❒ None of above

Nutrition/Hydration Status

1. **Weight**
   a. **Unintended weight loss of 5% or more in the last 30 days [or 10% or more in the last 180 days]**
   ❒ Yes
   ❒ No

   b. **Severe malnutrition (cachexia**)
   ❒ Yes
   ❒ No

   c. **Morbid obesity**
   ❒ Yes
   ❒ No

2. **Consumption**
   a. **In at least 2 of the last 3 days, ate one or fewer meals a day**
   ❒ Yes
   ❒ No

   b. **In last 3 days, noticeable decrease in the amount of food client usually eats or fluids usually consumes**
   ❒ Yes
   ❒ No

   c. **Insufficient fluid—did not consumer all/almost all fluids during last 3 days**
   ❒ Yes
   ❒ No

   d. **Enteral tube feeding**
   ❒ Yes
   ❒ No

3. **Swallowing**
❒ Normal—safe and efficient swallowing of all diet consistencies
❒ Requires modification to swallow solid foods (mechanical diet or able to ingest specific foods only)
❒ Requires medication to swallow solid foods and liquids (puree, thickened liquids)
❒ Combined oral and tube feeding
❒ No oral intake (NPO)

Dental Status (Oral Health)

1. **Oral Status** (check all that apply)
❒ Problem chewing (e.g., poor mastication, immobile jaw, surgical resection, decreased sensation/motor control, pain while eating)
❒ Mouth is "dry" when eating a meal
❒ Problem brushing teeth or dentures
❒ None of above

Skin Condition

1. **Skin Problems**
Any troubling skin conditions or changes in skin condition (e.g., burns, bruises, rashes, itchiness, body lice, scabies)
❒ Yes
❒ No

2. **Ulcers (Pressure/Stasis)**. Presence of an ulcer anywhere on the body. Ulcers include any area of persistent skin redness (Stage 1); partial loss of skin layers (Stage 2); dep craters in the skin (Stage 3); breaks in skin exposing muscle or bone (Stage 4). [Code 0 if no ulcer, otherwise record the highest ulcer stage (Stage 1-4)]
    a. Pressure ulcer—any lesion caused by pressure, shear forces, resulting in damage of underlying tissues _____
    b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities _____

3. **Other Skin Problems Requiring Treatment**. (check all that apply)
    ❒ Burns (second or third degree)
    ❒ Open lesions other than ulcers, rashes, cuts (e.g., cancer)
    ❒ Skin tears or cuts
    ❒ Surgical wound
    ❒ Corns, calluses, structural problems, infections, fungi
    ❒ None of above

4. **History of Resolved Pressure Ulcers**
    Client previously had (at any time) or has an ulcer anywhere on the body
    ❒ Yes
    ❒ No

5. **Wound/Ulcer Care** (Check for formal care in last 7 days)
    ❒ Antibiotics, systemic or topical
    ❒ Dressings
    ❒ Surgical wound care
    ❒ Other wound/ulcer care (e.g. pressure relieving device, nutrition, turning, debridement)
    ❒ None of above

6. **Special Treatments, Therapies, Programs**

    Special treatments, therapies, and programs received or scheduled during the last 7 days (or since last assessment if less than 7 days) and adherence to the required schedule. Includes services received in the home or on an outpatient basis.
    Blank = Not applicable
    1=Scheduled, full adherence as prescribed
    2= Scheduled, partial adherence
    3=Scheduled, not received
    [if no treatments provided, check none of above]

    Respiratory Treatments

    ❒ Oxygen
    ❒ Respirator for assistive breathing
    ❒ All other respiratory treatments

    Other Treatments

    ❒ Alcohol/drug treatment program
    ❒ Blood transfusion(s)
    ❒ Chemotherapy
    ❒ Dialysis
    ❒ IV infusion—central
    ❒ IV infusion-peripheral
    ❒ Mediation by injection
    ❒ Ostomy care
    ❒ Radiation
    ❒ Tracheostomy care

    Therapies

    ❒ Exercise therapy
    ❒ Occupational therapy
    ❒ Physical therapy

    Programs

    ❒ Day center
    ❒ Day hospital
    ❒ Hospice care
    ❒ Physician or clinic visit

❒ Respite care

Special Procedures Done in Home

❒ Daily nurse monitoring (e.g., EKG, urinary output)
❒ Nurse monitoring less than daily
❒ Medical alert bracelet or electronic security alert
❒ Skin treatment
❒ Special diet
❒ None of above

7. **Management of Equipment** (in last 3 days)
   0=Not used
   1=Managed on own
   2=Managed on own if laid out or with verbal reminders
   3=Partially performed by others
   4=Fully performed by others

   ❒ Oxygen
   ❒ IV
   ❒ Catheter
   ❒ Ostomy

8. **Visits in last 90 days or since last assessment**

   ____ Number of times admitted to hospital with an overnight stay
   ____ Number of times visited emergency room without an overnight stay
   ____ Emergent care—including unscheduled nursing, physician, or therapeutic visits to office or home

9. **Treatment Goals**
   Any treatment goals that have been met in the past 90 days (or since last assessment if less than 90 days)
   ❒ Yes
   ❒ No

10. **Overall Change in Care Needs**
    Overall self-sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days)
    ❒ Yes
    ❒ No

11. **Trade Offs**
    Because of limited funds, during the last month, client made trade-offs among purchasing prescribed medication, sufficient home heat, necessary physician care, adequate food, home care.
    ❒ Yes
    ❒ No