Needs Assessment Tool Form Instructions

The Needs Assessment Tool (NAT) is the assessment tool for the OPTIONS Program and its purpose is to gather information about the individual. The information contained in the NAT is used to determine an individual's service needs, strengths, resources, preferences, and goals to develop a person-centered care plan.

The Care Manager has the responsibility to ensure all sections of the NAT are completed accurately and in the manner described in these instructions. Accurate completion of the NAT will not only benefit the consumer, but will aid the Department of Aging (PDA) with quality initiatives and improve data integrity regarding the consumers served.

The NAT contains the VAMC Saint Louis University Mental Status (SLUMS) Examination. The SLUMS has been placed before the medical condition section and will be completed. Placing the mental examination before the medical section enables the Care Manager to determine the cognitive ability of the individual to answer questions pertaining to medical diagnoses and functional ability.

Medical conditions display drop-down boxes for each type of diagnoses. The category of "Other" for selections of diagnoses not provided and a Notes section for expanded documentation in each section is available. In addition to determining if a medical diagnosis or condition affects the individual's ability to function, questions are included to assist the Care Manager in determining who is managing care of the conditions and if additional care or assistance is needed.

The NAT contains an algorithm that will calculate a Needs Assessment Score (NAS). The NAS is used for placement on a wait list, if necessary, and is one of the factors of determining if the OPTIONS consumer would receive a cost cap exception. It is imperative ALL questions in the NAT be answered to ensure a correct NAS is calculated.
Care Managers, Assessors, Registered Nurses, Supervisors, and other appropriate staff will ensure that they use their individually assigned user ID's and passwords when logging into SAMS. The electronic signature in SAMS will indicate that the data recorded is complete and accurate. The electronic signature replaces the need for hard copy signatures.

In order to fully assess a consumer's needs, a NAT will be completed in person, in the consumer's home or other residential setting. There are some situations where a NAT may be initiated while a consumer is in a facility. The NAT is only considered complete when all areas are addressed and the Supervisor has approved and signed off on the tool.

Needs Assessment Tool Form Instructions

Questions with an asterisk (*) indicate that question captures information that is required for the National Aging Program Information System (NAPIS) reporting, which PDA uses for Federal reporting purposes.

1. INTRODUCTION
1.A. INDIVIDUAL'S IDENTIFICATION

Question 1: Date of the face to face interview for Needs Assessment Tool (NAT):

Using the MM/DD/YYYY format, document the date that the face to face interview was completed.

Question 2: Individual's Last Name:

Document the last name of the individual as it appears on his/her legal form of identification.

Question 3: Individual's First Name:

Document the first name of the individual as it appears on his/her legal form of identification.

Question 4: Individual's Middle Initial:

Document the individual's middle initial as it appears on his/her legal form of identification.

Question 5: Individual's Name Suffix (If applicable):

Document the name suffix (e.g. Sr. or Jr.).

Question 6: Individual's Nickname/ Alias:

Document the individual's nickname or alias (e.g. Josephine, alias Jay).

***Question 7: Individual's Date of Birth (DOB):**

Using the MM/DD/YYYY format, document the individual's date of birth.

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Question 8a: Individual's current gender identity (defined as one's inner sense of one's own gender) (Select one)

Document the individual's current gender identity.

***Question 8b: Individual's sex assigned on their birth certificate at birth (Select one):**

Document the sex assignment listed on the individual's birth certificate at birth.

Question 8c: Individual's sexual orientation (defined as one's identification of emotional, romantic, sexual, or affectional attraction to another person) (Select one):

Document the sexual orientation of the individual.

***Question 9: Individual's Ethnicity: (Check only one.)**

Document the individual's ethnicity as described by the individual. Select one response.

***Question 10: Individual's Race:**

Document the individual's race as described by the individual. Select one response.

Question 11: Individual's Social Security Number (SSN):

Enter the individual's SSN, if available. If unknown, leave blank.

Question 12a: Does the individual have a Medicaid number?

Select No, Yes or Pending. If Yes, enter the number in 1.A.12b.

Question 12b: Indicate Medicaid recipient number:

Enter the individual's Medicaid recipient number if applicable.

Question 13a: Does the individual have Medicare?

Select No or Yes. If Yes, enter the number in 1.A.13b.

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Question 13b: Indicate Medicare recipient number:

Enter the individual's Medicare recipient number if applicable.

Question 14a: Does the individual have any other insurance?

Select No, Yes or Don't Know. If Yes, enter the number in 1.A.14b.

Question 14b: Indicate other health insurance information:

Document the name of the individual's other health insurance if applicable.

1.B. ASSESSMENT INFORMATION

Question 1: PSA number conducting assessment:

Select the Agency PSA number.

Question 2: Indicate type of Needs Assessment Tool (NAT):

Document the type of assessment completed. Select one response.

Question 3: Where was the individual interviewed?

Document the location where the individual was interviewed. Select one response.

Question 4: Did the individual participate in the assessment?

Select No or Yes. If No, complete 1.B.5 and Document Details in Notes section.

Question 5: If anyone else participated during the time of the needs assessment, please document the name and relationship in Notes.

Document all present at the interview. Select all response(s) that apply. List the name(s) and relationship(s) in Notes section.

1.C. POWER OF ATTORNEY (POA)/ LEGAL GUARDIANSHIP

Question 1a: Does the individual have a legal guardian?

Select No or Yes. If No, Skip to 1.C.2a.

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Question 1b: Was proof of legal guardianship provided?

Select No or Yes.

Question 1c: Name of legal guardian:

Document the name of the legal guardian.

Question 1d: Complete address of legal guardian:

Document the complete address of the legal guardian**.**

Question 1e: Primary phone number of legal guardian:

Document the primary phone number of the legal guardian.

Question 1f: Secondary phone number of legal guardian:

Document any other secondary phone number where the legal guardian may be reached (if applicable).

Question 1g: E-mail address of legal guardian:

Document the legal guardian's e-mail address.

Question 2a: Does the individual have a Power of Attorney (POA)?

Select No or Yes. If No, Skip to 1.D.1a.

Question 2b: Proof of POA provided?

Select No or Yes.

Question 2c: Type of POA:

Document the type of Power of Attorney. If not listed, select "Other" and Document Details in Notes section.

Question 2d: Name of POA:

Document the name of the Power of Attorney.

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Question 2e: Complete address of POA:

Document the complete address of the Power of Attorney.

Question 2f: Primary phone number of POA:

Document the primary phone number of the Power of Attorney.

Question 2g: Secondary phone number of POA:

Document any other secondary phone number where the Power of Attorney may be reached (if applicable).

Question 2h: E-mail address of POA:

Document the e-mail address of the Power of Attorney.

1.D. INDIVIDUAL'S DEMOGRAPHICS

Question 1a: Is the individual homeless?

Select No or Yes. If No, Skip to 1.D.2.

A homeless person is an individual without permanent housing who may live on the street; stay in a shelter, mission, single room occupancy, abandoned building or vehicle; or in any other unstable or non-permanent situation.

Question 1b: Does the individual have a place to stay tonight?

Select No or Yes. If No, Document Details in Notes section.

Question 1c: Does the individual have a place to stay long-term?

Select No or Yes. If No, Document Details in Notes section.

Question 1d: Explain homeless situation:

Select appropriate response(s). If not listed, select "Other" and Document Details in Notes section.

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***Question 2: Type of PERMANENT residence in which the individual resides:**

Document type of residence the individual lives in. Select one response.

***Question 3: What is the individual's PERMANENT living arrangement? (Include in the "Lives Alone" category, individuals who live in an AL, DC, or PCH, pay rent and have NO ROOMMATE.):**

Document the appropriate primary living arrangement. If the individual lives in Assisted Living, Dom Care, or PCH, pays rent and has no roommate, select the "Lives Alone" box and document the type of living arrangement in Notes section.

NOTE: If the consumer resides with their spouse, select "Lives with Spouse Only" regardless if other individuals reside in the home. This selection will ensure the cost share calculation includes the income of the spouse in the algorithm.

***Question 4: Individual's marital status:**

Select the marital status of the individual. Select one response.

***Question 5a: Is the individual a Veteran?**

Select No, Yes or Unable to Determine. If Unable to Determine, Document Details in Notes section.

Question 5b: Is the individual the spouse/ widow or dependent child of a Veteran?

Select No, Yes or Unable to Determine. If Unable to Determine, Document Details in Notes section.

Question 5c: Is the individual receiving Veteran's benefits?

Select No, Yes or Unable to Determine. If Unable to Determine, Document Details in Notes section.

***Question 6a: Does the individual require communication assistance?**

Select No, Yes, or Unable to Determine. If No, Skip to 1.D.7a. If Unable to Determine, Document Details in Notes section.

Question 6b: What type of communication assistance is required?

Select the type of assistance the individual requires for communication. If the individual is unable to communicate, the Care Manager should select the response titled “Unable to Communicate.” Document Details in Notes section to clarify type of assistance such as: interpreter or Assistive Technology assistance (e.g.: letter board).

Question 7a: Does the individual use sign language as their PRIMARY language?

Select No or Yes. If No, Skip to 1.D.8.

Question 7b: What type of sign language is used?

Select the individual’s type of sign language used. If not listed, select “Other” and Document Details in Notes section.

***Question 8: What is the individual’s PRIMARY language?**

Select the primary language understood and used by the individual. If not listed, select “Other” and Document Details in Notes section.

1.E. INDIVIDUAL’S PERMANENT RESIDENTIAL ADDRESS INFORMATION - MUNICIPALITY IS REQUIRED

Question 1: Is the individual’s postal/ mailing address exactly the same as the residential address?

Select No or Yes. If No, Complete Section 1.E. & 1.F. If Yes, complete Section 1.E. and skip to Section 1.G.

Question 2a: Residential County:

Select the name of the County where the individual resides.

Question 2b: Residential Street Address:

Document the street address where the individual resides.

Question 2c: Residential Address Second Line (Apt or Room #, Building or Complex Name, etc.):

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Document the Apartment # or Room # and the name of the building or complex (if applicable) where the individual resides (e.g. Apt #3 Independence Court)

***Question 2d: Residential Municipality – REQUIRED (usually a Township or Boro where the individual votes, pays taxes):**

Document the Township or Borough where the individual votes and pays taxes.

Question 2e: Residential City/Town:

Document the city or town where the individual resides.

Question 2f: Residential State:

Document the state where the individual resides.

Question 2g: Residential Zip Code:

Document the zip code where the individual resides.

Question 3: Directions to the individual's home:

Document the directions to the individual's home.

***Question 4: Does individual reside in a rural area?**

This question will automatically populate based on the municipality entered in Question 2d.

Question 5a: Primary Phone Number:

Document the PRIMARY phone number of the individual.

Question 5b: Mobile Phone Number:

Document the individual's mobile phone number (if applicable).

Question 5c: Other Phone Number (Enter number where individual can be reached.):

Document any other ancillary phone number where an individual may be reached.

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Question 5d: E-mail Address:

Document the individual's e-mail address.

***Question 6: What was the outcome when the individual was offered a voter registration form? REQUIRED:**

Select the appropriate response.

NOTE: The AAA is not responsible to provide voter registration to Nursing Facility residents. Under the Code of Federal Regulations (CFR) this is the responsibility of the staff at the nursing facility. It is not a problem if you elect to ask the question; however, if you do not ask the question document "NF" in Notes section.

1.F. INDIVIDUAL'S POSTAL/MAILING ADDRESS INFORMATION

The purpose of this section is to document the individual's postal/mailing address which may not be the same as their residential address.

Question 1a: Postal Street Address:

Document the street address where the individual receives mail.

Question 1b: Postal Address Line 2 (Optional):

Document the Apartment # or Room # and the name of the building or complex (if applicable). e.g. Apt #3 Independence Court.

Question 1c: Postal City/ Town:

Document the city or town where the individual receives mail.

Question 1d: Postal State:

Document the state where the individual receives mail.

Question 1e: Postal Zip Code:

Document the postal zip code where the individual receives mail.

1.G. EMERGENCY CONTACT

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Question 1: Name of Emergency Contact:

Document the name of the emergency contact for the individual.

Question 2: Relationship of Emergency Contact:

Document the relationship of the emergency contact to the individual.

Question 3: Telephone Number of Emergency Contact:

Document the telephone number of the emergency contact.

Question 4: Work Telephone Number of Emergency Contact:

Document the work telephone number of the emergency contact.

2. USE OF MEDICAL SERVICES
2.A. HOSPITAL, NURSING FACILITY, ER, INPATIENT PSYCHIATRIC VISITS/STAYS

Admission categories include inpatient admission or outpatient observation status. An individual is an inpatient when formally admitted to a hospital with a doctor's order. Outpatient observation is not considered a hospital admission. An outpatient receives emergency department services, observation services, outpatient surgery, lab tests, X-rays, or any other hospital services, and the doctor has not written an order to admit the individual to a hospital as an inpatient. In these cases, the individual is considered an outpatient even if they spend the night at the hospital.

Question 1: Has the individual stayed in the HOSPITAL in the LAST 12 MONTHS?

Select No, Yes, or Unable to Determine. If No, Skip to 2.A.3. If Yes, Complete 2.A.2. If Unable to Determine, Document Details in Notes section.

NOTE: Stayed means the individual was admitted to the hospital.

Question 2: The approximate number of times the individual has stayed overnight in the HOSPITAL in the LAST 12 MONTHS. Document Details in Notes:

Document the number of times the individual was admitted to a hospital in last 12 months. Document Details in Notes section.

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NOTE: Number of times does not mean days in the hospital, but number of separate times the individual was admitted to the hospital.

Question 3: The approximate number of times the individual has visited the ER in the LAST 12 MONTHS and was NOT admitted:

Document the number of times the individual visited the ER in the last 12 months and was not admitted. Document Details in Notes section.

Question 4: The approximate number of times the individual was admitted to a NURSING FACILITY in the LAST 12 MONTHS: Document Details in Notes.

Document the number of times the individual stayed at the Nursing Facility in the last 12 months. Document Details in Notes section.

NOTE: Number of times does not mean days in the nursing facility, but number of times the individual was admitted to the nursing facility.

Question 5: The approximate number of times the individual was an inpatient in a PSYCHIATRIC Facility in the LAST 24 MONTHS: Document Details in Notes.

Document the number of times the individual has had inpatient Psychiatric Visits/Stays in the last 24 months. Document Details in Notes section.

NOTE: Number of times does not mean days in the psychiatric facility, but number of separate times the individual was admitted to the psychiatric facility.

Question 6: The number of times the individual has had outpatient surgery in the LAST 12 MONTHS:

Document the number of times the individual has had outpatient surgery in the last 12 months. If not listed, select “Other” and Document Details in Notes section.

2.B. PRIMARY PHYSICIAN INFORMATION

Question 1: Does the individual have a PRIMARY care physician?

Select No or Yes. If No, Document Details in Notes section.

Question 2: PRIMARY Physician's Name:

Document the name of the individual’s primary physician.

Question 3: PRIMARY Physician’s Street Address:

Document the primary physician’s street address.

Question 4: PRIMARY Physician's City or Town:

Document the primary physician's city or town.

Question 5: PRIMARY Physician's State:

Document the primary physician's state.

Question 6: PRIMARY Physician's Zip Code:

Document the primary physician's zip code.

Question 7: PRIMARY Physician's Business Phone Number: (Requires 10 digits to transfer to SAMS, optional 1-5 digit extension.)

Document the primary physician's 10-digit telephone number. A 1-5 digit extension is optional.

Question 8: PRIMARY Physician's FAX Number:

Document the primary physician's 10-digit fax number.

Question 9: PRIMARY Physician's E-MAIL ADDRESS:

Document the primary physician's e-mail address.

Question 10: Additional Physicians:

Document names and contact information of any additional physicians for the individual (if applicable). Document Details in Notes section.

Question 11: Does the individual receive alternative medical care from a practitioner?

Select No or Yes. If No, Skip to 3.A.1. If Yes, Complete 2.B.12.

Question 12: Select the type of alternative medical care-Document Details in Notes:

Select the type of alternative medical care that the individual is receiving. If not listed, select "Other" and Document Details in Notes section.

3. SAINT LOUIS UNIVERSITY MENTAL STATUS (SLUMS)

The SLUMS identifies the subtle symptoms of dementia and allows individuals to seek medical intervention early for the treatment of dementia. Early intervention may affect

the disease process. The SLUMS consists of 11 items, and measures aspects of cognition that include orientation, short-term memory, calculations, naming of animals, clock drawing, and recognition of geometric figures. The SLUMS is a screening test and does not substitute for a full diagnostic work-up for Alzheimer's disease and related disorders.

Scores range from 0 to 30, with scores of 27-30 considered normal in a person with a high school education. Scores between 21 and 26 suggest Mild Neurocognitive Disorder, and scores between 0 and 20 indicate dementia.

Prior to conducting the SLUMS Exam, the Care Manager needs to determine that the individual is alert and that they are fully awake and able to focus. This is determined by asking and documenting questions 3.A.1-4. The Care Manager would not do the exam if the individual presents with the following:

- Extremely ill
- Falling asleep
- Blind
- Unable to write
- Drowsy/confused/distracted/preoccupied

The Care Manager needs to be prepared for the exam by having the following materials available:

- Watch with a second hand
- Form with clock outline and geometric figures

Cognitive refers to brain processes such as thinking, attention, perception, learning, memory, reasoning, problem solving, decision making, and planning. Cognitive processes are distinguished from emotional processes (feelings) and behavioral processes (actions).

Orientation refers to the cognitive ability of an individual to know who they are, where they are, and what day and year it is. Assessment of orientation is an important part of any mental status examination, as it helps to evaluate the changes that a disease process may have brought about.

Cognitive symptoms refer to problems with the processes mentioned above in the cognition definition, such as thinking, memory, and learning.

Mild Neurocognitive Disorder (MNCD) occur as people progress from normal aging to early Alzheimer’s.

Mild Cognitive Impairment (MCI) is the type of memory loss once considered normal that now may be seen as an early sign of disease.

3.A. SLUMS PREPARATION

Question 1: Determine if the individual is alert. Alert indicates that the individual is fully awake and able to focus.

Select one response which best indicates the individual's current level of alertness.

Question 2: Do you have trouble with your memory?

Select No or Yes.

NOTE: Be aware that many people with dementia will answer that question by indicating "no". A common symptom of persons with dementia is anosognosia (the literal translation is that "they do not know that they do not know"). Thus, if an individual says "no", one cannot conclude that they are free of cognitive impairment.

Question 3: SLUMS is being completed as which of the following?

Select one response.

Question 4: May I ask you some questions about your memory?

Select No, Yes, or Other. If No or "Other", Document Details in Notes section.

Question 5: Is the individual able to complete the SLUMS Exam?

Select No or Yes. If No, Document Details in Notes section. If the individual refuses to take the test, Document Details in Notes section and proceed to Section 3.D.1a.

3.B. SLUMS QUESTIONNAIRE (Each score is beside the response.)

Question 1: What DAY of the week is it?

Document the individual's response to the question as correct or incorrect.

NOTE: Remember the answer is incorrect if the individual does not answer.

Question 2: What is the YEAR?

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Document the individual's response to the question as correct or incorrect.

Question 3: What is the name of the STATE we are in?

Document the individual's response to the question as correct or incorrect.

Question 4: Please remember these five objects, I will ask you what they are later. Apple, Pen, Tie, House, Car:

Recite the five objects to the individual clearly and slowly. Ask the individual to repeat them back to you and tell them that you will ask them again later. The Care Manager may repeat the objects as many times as it takes for the individual to repeat them back correctly.

The response to this question is recorded in question #7.

Question 5a: You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20. How much did you spend?

Document the individual's response to the question as correct, incorrect or unanswered.

Question 5b: How much do you have left?

Document the individual's response to the question as correct, incorrect, or unanswered.

The Care Manager may repeat the question once and will not give the individual any hints to the answer.

Question 6: Please name as many animals as you can in one minute:

Select the appropriate response. The Care Manager may accept names of animals only and not categories. Names of birds and fish are acceptable answers. Give the individual one minute to answer and be sure to time them.

Question 7: What were the five objects I asked you to remember? (1 point for each one correct.):

Select each response that the individual answers correctly.

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Question 8: I am going to give you a series of numbers and I would like you to give them to me backwards. For example, if I say four-two, you would say two-four.

The Care Manager should state each number by its individual name. 87 is pronounced eight, seven; 649 is pronounced six, four, nine; 8537 is pronounced eight, five, three, seven.

Select each response that the individual answers correctly.

Question 9: This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock:

This is the clock drawing. The Care Manager will need to utilize the form with clock face and geometric figures. The hour hand will be shorter than the minute hand and the minute hand will point at the 10 and the hour hand point at the 11.

Select each response that the individual answers correctly.

Question 10a: Place an X in the triangle:

The Care Manager will utilize the same form as the clock diagram or enlarge the diagrams on a separate sheet of paper to accommodate those with visual impairments.

Document the individual's response to the question as correct or incorrect.

Question 10b: Which of the figures is the largest?

The Care Manager asks the individual to place an X in the triangle. Then the Care Manager asks the individual "Which of the above figures is largest?"
Document the individual's response to the question as correct or incorrect.

Question 11: I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you some questions about it.

Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.

The Care Manager should not repeat the story but read it slowly and make sure the individual is paying attention. The answer of Chicago as the state gets no credit but the Care Manager may prompt the individual once by repeating the question.

Select each response that the individual answers correctly.

3.C. SLUMS RESULTS

Question 1: SLUMS Consumers Total Score:

This will be an INDICATOR. The score for this exam will be automatically calculated in the NAT.

Question 2: Record the highest grade (1-12) the individual completed in school:

Document the highest grade (1-12) the individual completed in school.

Question 3: Identify the highest educational degree that the individual obtained:

Select one response.

Question 4: Care Manager's conclusion after completion of the individual's SLUMS Exam:

Select one response based on the SLUMS Score and the education level.

3.D. COGNITIVE FUNCTION

Question 1a: Does the individual exhibit any cognitive impairments?

Select No or Yes. If No, Skip to 4.A.1. If Yes, Complete 3.D.

Question 1b: Does this impairment interfere with the individual's ability to function daily?

Select No or Yes. If No, Skip to 4.A.1. If Yes, Document Details in Notes section.

Question 1c: Is the individual able to direct/supervise his own care with the impairment?

Select No or Yes. If No, Complete 3.D.1d.

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Question 1d: Does the individual have a representative who is able and willing to direct the individual's care because of the impairment?

Select No or Yes. If No, Skip to 4.A.1. If Yes, Complete 3.D.1e.

Question 1e: Document contact information (Name, Relationship, Phone Number, etc.) of the individual who is willing to supervise care. Additional space in Notes:

Document the contact information of the individual who is willing to supervise care. Document Details in Notes section, if needed.

4. DIAGNOSES

The purpose of this section is to document six important questions:

- Individual's diagnoses or conditions specified in each question.
- Signs and symptoms specific to each medical diagnosis or condition.
- If the individual is being treated for the medical conditions.
- Do the diagnoses affect the individual's ability to function?
- Who is managing the care of the individual's conditions?
- Does the individual need additional assistance in managing the care of their medical condition?

Self-manage: Having the knowledge, awareness and capability to manage their care as it pertains to a diagnosis or disability. This would include treatments or any prescribed medical measures for the diagnosis as directed by the individual's physician.
All questions will be answered. There may be more than one diagnosis in each section. Select the correct boxes for each and document additional details in the Notes section about the diagnosis. In the event that there are no selections listed for the diagnosis, select "Other" and Document Details in Notes section.

Some medical terminology may not be familiar. A resource guide is located on the last page of this document which may be helpful.

4.A. RESPIRATORY

Question 1: Select all RESPIRATORY diagnoses:

Select appropriate response(s) for all diagnoses. If None, Skip to 4.B.1. If not listed, select "Other" and Document Details in Notes section.

Question 2: Signs and symptoms of RESPIRATORY diagnoses:

Select appropriate response(s) for all signs and symptoms specific to Respiratory diagnoses. If current signs and symptoms are not listed, select “Other” and Document Details in Notes section.

Question 3: Current treatments for RESPIRATORY diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If medications is selected, list in 9.D.3. If the treatment is not listed, select “Other” and Document Details in Notes section.

Question 4: Do the RESPIRATORY diagnoses affect the individual’s ability to function?

Select No or Yes. If Yes, Document Details in Notes section.

Question 5: Who manages care of the RESPIRATORY condition(s)?

Select appropriate response(s) for who manages care of the condition. If not listed, select “Other” and Document Details in Notes section.

Question 6: Does the individual need additional assistance beyond that available from existing or accessible informal and formal supports in managing the care of the RESPIRATORY condition(s)?

Select No or Yes. If Yes, Document Details in Notes section.

4.B. HEART/ CIRCULATORY SYSTEMS

Question 1: Select all HEART/CIRCULATORY systems diagnoses:

Select appropriate response(s) for all diagnoses. If None, Skip to 4.C.1. If not listed, select “Other” and Document Details in Notes section.

Question 2: Signs and symptoms of HEART/CIRCULATORY systems diagnoses:

Select appropriate response(s) for all signs and symptoms specific to Heart/ Circulatory system diagnoses. If current signs and symptoms are not listed, select “Other” and Document Details in Notes section.

Question 3: Current treatments for HEART/CIRCULATORY systems diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Medications is selected, List in 9.D.3. If the treatment is not listed, select “Other” and Document Details in Notes section.

Question 4: Do the HEART/CIRCULATORY systems diagnoses affect the individual’s ability to function?

Select No or Yes. If Yes, Document Details in Notes section.

Question 5: Who manages care of the HEART/ CIRCULATORY systems condition(s)?

Select appropriate response(s) for who manages care of the condition. There may be more than one selection. If not listed, select “Other” and Document Details in Notes section.

Question 6: Does the individual need additional assistance beyond that available from existing or accessible informal and formal supports in managing the care of the HEART/ CIRCULATORY systems condition(s)?

Select No or Yes. If Yes, Document Details in Notes section.

4.C. GASTROINTESTINAL

Question 1: Select all GASTROINTESTINAL diagnoses:

Select appropriate response(s) for all diagnoses. If None, Skip to 4.D.1. If not listed, select “Other” and Document Details in Notes section.

Question 2: Signs and symptoms of GASTROINTESTINAL diagnoses:

Select appropriate response(s) for all signs and symptoms specific to Gastrointestinal diagnoses. If current signs and symptoms are not listed, select “Other” and Document Details in Notes section.

Question 3: Current treatments for GASTROINTESTINAL diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Medications is selected, List in 9.D.3. If the treatment is not listed, select “Other” and Document Details in Notes section.

Question 4: Do the GASTROINTESTINAL diagnoses affect the individual’s ability to function?

Select No or Yes. If Yes, Document Details in Notes section.

Question 5: Who manages care of the GASTROINTESTINAL condition(s)?

Select appropriate response(s) for who manages care of the condition. If not listed, select “Other” and Document Details in Notes section.

Question 6: Does the individual need additional assistance beyond that available from existing or accessible informal and formal supports in managing the care of the GASTROINTESTINAL condition(s)?

Select No or Yes. If Yes, Document Details in Notes section.

4.D. MUSCULOSKELETAL

Question 1: MUSCULOSKETAL diagnoses and/or signs and symptoms of MUSCULOSKELETAL diagnoses:

Select appropriate response(s) for all diagnoses and/or signs/symptoms specific to Musculoskeletal diagnoses. If None, Skip to 4.E.1. If not listed, select “Other” and Document Details in Notes section.

Question 2: Current treatments for MUSCULOSKELETAL diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Medications is selected, List in 9.D.3. If the treatment is not listed, select “Other” and Document Details in Notes section.

Question 3: Do the MUSCULOSKELETAL diagnoses affect the individual’s ability to function?

Select No or Yes. If Yes, Document Details in Notes section.

Question 4: Who manages care of the MUSCULOSKELETAL condition(s)?

Select appropriate response(s) for who manages care of the condition. If not listed, select “Other” and Document Details in Notes section.

Question 5: Does the individual need additional assistance beyond that available from existing or accessible informal and formal supports in managing the care of the MUSCULOSKELETAL condition(s)?

Select No or Yes. If Yes, Document Details in Notes section.

4.E. SKIN

Refer to RESOURCES at the end of these instructions for Ulcer Staging.

Question 1: Select all SKIN diagnoses:

Select appropriate response(s) for all diagnoses. If None, Skip to 4.F.1. If not listed, select “Other” and Document Details in Notes section.

Question 2: Check ALL affected SKIN location(s):

Select appropriate response(s). If not listed, select “Other” and Document Details in Notes section.

Question 3: Identify the highest known ULCER STAGE:

Select one appropriate response. The Care Manager may have to refer to a medical professional or the medical record for this information.

Question 4: Signs and symptoms of the SKIN diagnoses:

Select appropriate response(s) for all signs and symptoms specific to Skin diagnoses. If current signs and symptoms are not listed, select “Other” and Document Details in Notes section.

Question 5: Current treatments for SKIN diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Medications is selected, List in 9.D.3. If the treatment is not listed, select “Other” and Document Details in Notes section.

Question 6: Do the SKIN diagnoses affect the individual’s ability to function?

Select No or Yes. If Yes, Document Details in Notes section.

Question 7: Who manages care of the SKIN condition(s)?

Select appropriate response(s) for who manages care of the condition. If not listed, select “Other” and Document Details in the Notes section.

Question 8: Does the individual need additional assistance beyond that available from existing or accessible informal and formal supports in managing the care of the SKIN condition(s)?

Select No or Yes. If Yes, Document Details in Notes section.

4.F. ENDOCRINE/METABOLIC SYSTEMS

Question 1: Select all ENDOCRINE/ METABOLIC systems diagnoses:

Select appropriate response(s) for all diagnoses. If None, Skip to 4.G.1. If not listed, select "Other" and Document Details in Notes section.

Question 2: Signs and symptoms of ENDOCRINE/METABOLIC systems diagnoses:

Select appropriate response(s) for all signs and symptoms specific to Endocrine/ Metabolic diagnoses. If current signs and symptoms are not listed, select "Other" and Document Details in Notes section.

Question 3: Current treatments for ENDOCRINE/METABOLIC systems diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Medications is selected, List in 9.D.3. If the treatment is not listed, select "Other" and Document Details in Notes section.

Question 4: Do the ENDOCRINE/METABOLIC systems diagnoses affect the individual's ability to function?

Select No or Yes. If Yes, Document Details in Notes section.

Question 5: Who manages care of the ENDOCRINE/METABOLIC systems condition(s)?

Select appropriate response(s) for who manages care of the condition. If not listed, select "Other" and Document Details in Notes section.

Question 6: Does the individual need additional assistance beyond that available from existing or accessible informal and formal supports in managing the care of the ENDOCRINE/ METABOLIC systems condition(s)?

Select No or Yes. If Yes, Document Details in Notes section.

4.G. GENITOURINARY

Question 1: Select all GENITOURINARY diagnoses:

Select appropriate response(s) for all diagnoses. If None, Skip to 4.H.1. If not listed, select “Other” and Document Details in Notes section.

Question 2: Signs and symptoms of the GENITOURINARY diagnoses:

Select appropriate response(s) for all signs and symptoms specific to Genitourinary diagnoses. If current signs and symptoms are not listed, select “Other” and Document Details in Notes section.

Question 3: Current treatments for GENITOURINARY diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Catheter is selected, Complete 4.G.4. If Medications is selected, List in 9.D.3 If the treatment is not listed, select “Other” and Document Details in Notes section.

Question 4: If the individual has a catheter, indicate the type:

Select the appropriate response. If the type is not listed, select “Other” and Document Details in Notes section.

Question 5: Do the GENITOURINARY diagnoses affect the individual’s ability to function?

Select No or Yes. If Yes, Document Details in Notes section.

Question 6: Who manages care of the GENITOURINARY condition(s)?

Select appropriate response(s) for who manages care of the condition. If not listed, select “Other” and Document Details in Notes section.

Question 7: Does the individual need additional assistance beyond that available from existing or accessible informal and formal supports in managing the care of the GENITOURINARY condition(s)?

Select No or Yes. If Yes, Document Details in Notes section.

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4.H. GYNECOLOGICAL

NOTE: This section is only required for females.

Question 1: Select all GYNECOLOGICAL diagnoses:

Select appropriate response(s) for all diagnoses. If None, Skip to 4.I.1. If not listed, select “Other” and Document Details in Notes section.

Question 2: Signs and symptoms of GYNECOLOGICAL diagnoses:

Select appropriate response(s) for all signs and symptoms specific to Gynecological diagnoses. If current signs and symptoms are not listed, select “Other” and Document Details in Notes section.

Question 3: Current treatments for GYNECOLOGICAL diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Medications is selected, List in 9.D.3. If the treatment is not listed, select “Other” and Document Details in Notes section.

Question 4: Do the GYNECOLOGICAL diagnoses affect the individual’s ability to function?

Select No or Yes. If Yes, Document Details in Notes section.

Question 5: Who manages care of the GYNECOLOGICAL condition(s)?

Select appropriate response(s) for who manages care of the condition. If not listed, select “Other” and Document Details in Notes section.

Question 6: Does the individual need additional assistance beyond that available from existing or accessible informal and formal supports in managing the care of the GYNECOLOGICAL condition(s)?

Select No or Yes. If Yes, Document Details in Notes section.

4.I. INFECTIONS/IMMUNE SYSTEMS

Question 1: Select all INFECTION/ IMMUNE system diagnoses:

Select appropriate response(s) for all diagnoses. If None, Skip to 4.J.1. If not listed, select “Other” and Document Details in Notes section.

Question 2: If HIV or AIDS is indicated in 4.I.1., has the individual ever had lab results of CD4 count under 400?

Select No, Yes or Unknown. Document Details in Notes section if needed.

Question 3: List all the signs and symptoms of INFECTION/ IMMUNE system conditions. Use Notes for additional text:

Document all signs and symptoms specific to INFECTIONS/ IMMUNE system conditions. Document Details in Notes section if needed.

Question 4: Current treatments for INFECTION/ IMMUNE system diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Medications is selected, List in 9.D.3 If the treatment is not listed, select "Other" and Document Details in Notes section.

Question 5: Do the INFECTIONS/ IMMUNE system diagnoses affect the individual's ability to function?

Select No or Yes. If Yes, Document Details in Notes section.

Question 6: Who manages care of the INFECTION/ IMMUNE system condition(s)?

Select appropriate response(s) for who manages care of the condition. If not listed, select "Other" and Document Details in Notes section.

Question 7: Does the individual need additional assistance beyond that available from existing or accessible informal and formal supports in managing the care of the INFECTIONS/IMMUNE system condition(s)?

Select No or Yes. If Yes, Document Details in Notes section.

4.J. CANCER

Question 1: Does the individual have any current CANCER diagnoses?

Select No or Yes, If No, Skip to 4.K.1.

Question 2: If Yes, identify the STAGE of CANCER:

Select one response. The Care Manager may have to refer to the medical record or the individual's physician to obtain the correct stage of cancer.

Question 3: Select all current CANCER diagnoses:

Select appropriate response(s) for all Cancer diagnoses. If not listed, select "Other" and Document Details in Notes section.

Question 4: Signs and symptoms of the CANCER diagnoses:

Select appropriate response(s) for all signs and symptoms specific to Cancer diagnoses. If current signs and symptoms are not listed, select "Other" and document details in Notes
section.

Question 5: Current treatments for CANCER diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Medications is selected, List in 9.D.3. If the treatment is not listed, select "Other" and Document Details in Notes section.

Question 6: Do the CANCER diagnoses affect the individual's ability to function?

Select No or Yes. If Yes, Document Details in Notes section.

Question 7: Who manages care of the CANCER condition(s)?

Select appropriate response(s) for who manages care of the condition. If not listed, select "Other" and Document Details in Notes section.

Question 8: Does the individual need additional assistance beyond that available from existing or accessible informal and formal supports in managing the care of the CANCER condition(s)?

Select No or Yes. If Yes, Document Details in Notes section.

4.K. EARS, NOSE & THROAT (ENT)

Question 1: Select all ENT diagnoses:

Select appropriate response(s) for all diagnoses. If None, Skip to 4.L.1. If not listed, select "Other" and Document Details in Notes section.

Question 2: Signs and symptoms of the ENT diagnoses:

Select appropriate response(s) for all signs and symptoms specific to ENT diagnoses. If current signs and symptoms are not listed, select “Other” and Document Details in Notes section.

Question 3: Current treatments for ENT diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Medications is selected, List in 9.D.3. If the treatment is not listed, select “Other” and Document Details in Notes section.

Question 4: Do the ENT diagnoses affect the individual’s ability to function?

Select No or Yes. If Yes, Document Details in Notes section.

Question 5: Who manages care of the ENT condition(s)?

Select appropriate response(s) for who manages care of the condition. If not listed, select “Other” and Document Details in Notes section.

Question 6: Does the individual need additional assistance beyond that available from existing or accessible informal and formal supports in managing the care of the ENT condition(s)?

Select No or Yes. If Yes, Document Details in Notes section.

4.L. EYES

Question 1: What EYE diagnoses/disorders have been confirmed and documented by health/medical professionals?

Select appropriate response(s) for all diagnoses/disorders that have been confirmed and documented by health/medical professionals. If None, Skip to 4.M.1. If not listed, select “Other Visual Impairments” and Document Details in Notes section.

Question 2: Signs and symptoms for EYE conditions and/or diagnoses:

Select appropriate response(s) for all signs and symptoms specific to eye conditions and/or diagnoses. If current signs and symptoms are not listed, select “Other” and Document Details in Notes section.

Question 3: Current treatments for EYE conditions and/or diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Medications is selected, List in 9.D.3. If the treatment is not listed, select “Other” and Document Details in Notes section.

Question 4: Do the EYE diagnoses affect the individual’s ability to function?

Select No or Yes. If Yes, Document Details in Notes section.

Question 5: Who manages care of the EYE condition(s)?

Select appropriate response(s) for who manages care of the condition. If not listed, select “Other” and Document Details in Notes section.

Question 6: Does the individual need additional assistance beyond that available from existing or accessible informal and formal supports in managing the care of the EYE condition(s)?

Select No or Yes. If Yes, Document Details in Notes section.

4.M. MOUTH

Question 1: Select all MOUTH conditions and/or diagnoses:

Select appropriate response(s) for all diagnoses. If None, Skip to 5.A.1. If not listed, select “Other” and Document Details in Notes section.

Question 2: Current treatments for MOUTH conditions and/or diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Medications is selected, List in 9.D.3. If the treatment is not listed, select “Other” and Document Details in Notes section.

Question 3: Signs and symptoms of MOUTH conditions and/or diagnoses:

Select appropriate response(s) for all signs and symptoms specific to mouth conditions and/or diagnoses. If current signs and symptoms are not listed, select “Other” and Document Details in Notes section.

Question 4: Do the MOUTH diagnoses affect the individual’s ability to function?

Select No or Yes. If Yes, Document Details in Notes section.

Question 5: Who manages care of the MOUTH condition(s)?

Select appropriate response(s) for who manages care of the condition. If not listed, select “Other” and Document Details in Notes section.

Question 6: Does the individual need additional assistance beyond that available from existing or accessible informal and formal supports in managing the care of the MOUTH conditions and/or diagnoses?

Select No or Yes. If Yes, Document Details in Notes section.

5. NEUROLOGICAL (Mandatory completion of Section 8 if Neurological diagnosis
5.A. NEUROLOGICAL

Question 1: If there are NEUROLOGICAL diagnoses, select all types & completion of Section 8 (Behaviors) is MANDATORY.

Select appropriate response(s) for all types of Neurological diagnoses. If None, skip to 6.A.1. If not listed, select “Other” and Document Details in Notes section.

Question 2: What characteristics describe the individual’s COGNITIVE state?

Select the correct response(s). If not listed, select “Other” and Document Details in Notes section.

Question 3: Signs and symptoms of NEUROLOGICAL diagnoses:

Select appropriate response(s) for all signs and symptoms specific to Neurological diagnoses. If current signs and symptoms are not listed, select “Other” and Document Details in Notes section.

Question 4: Current treatments for NEUROLOGICAL diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Medications is selected, List in 9.D.3. If the treatment is not listed, select “Other” and Document Details in Notes section.

Question 5: Do the NEUROLOGICAL diagnoses affect the individual’s ability to function?

Select No or Yes. If Yes, Document Details in Notes section.

Question 6: Who manages care of the NEUROLOGICAL condition(s)?

Select appropriate response(s) for who manages care of the condition. If not listed, select “Other” and Document Details in Notes section.

Question 7: Does the individual need additional assistance beyond that available from existing or accessible informal and formal supports in managing the care of the NEUROLOGICAL condition(s)?

Select No or Yes. If Yes, Document Details in Notes section.

6. INTELLECTUAL/DEVELOPMENTAL DISABILITY (I/DD) (MANDATORY completion of Section 8 if I/DD diagnosis)
6.A. INTELLECTUAL/DEVELOPMENTAL DISABILITY (I/DD)

Question 1: Does the individual have a diagnosis of Intellectual/ Developmental Disability (I/DD) from birth to 22nd birthday or known to the ID system?

Select No or Yes. If No, Skip to 7.A.1. If Yes, Completion of Section 8 (Behaviors) is MANDATORY.

Question 2: Is the individual able to self-manage care of the I/DD condition?

Select the appropriate response. If No or Unable to Determine, Document Details in Notes section.

Question 3: Does the I/DD diagnosis affect the individual’s ability to function?

Select the appropriate response. If Yes or Unable to Determine, Document Details in Notes section.

7. MENTAL HEALTH (MANDATORY completion of Section 8 if Psychiatric diagnosis)
7.A. PSYCHIATRIC

Question 1: If there are PSYCHIATRIC diagnoses, select all types & completion of Section 8 (Behaviors) is MANDATORY.

Select appropriate response(s) for all diagnoses. If None, Skip to 7.B.1. If not listed, select “Other” and Document Details in Notes section.

Question 2: Signs and symptoms of PSYCHIATRIC conditions:

Select appropriate response(s) for all signs and symptoms specific to Psychiatric diagnoses. If current signs and symptoms are not listed, select “Other” and Document Details in Notes section.

Question 3: Current treatments for PSYCHIATRIC diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Medications is selected, List in 9.D.3. If the treatment is not listed, select “Other” and Document Details in Notes section.

Question 4: Do the PSYCHIATRIC diagnoses affect the individual’s ability to function?

Select No or Yes. If Yes, Document Details in Notes section.

Question 5: Who manages care of the PSYCHIATRIC condition(s)?

Select appropriate response(s) for who manages care of the condition. If not listed, select “Other” and Document Details in Notes section.

Question 6: Does the individual need additional assistance beyond that available from existing or accessible informal and formal supports in managing the care of the PSYCHOLOGICAL condition(s)?

Select No or Yes. If Yes, Document Details in Notes section.

7.B. SUICIDE SCREENING

The incidence in suicide of older individuals is very high; therefore, the questions in this section are extremely important to ask in order to determine a consumer’s risk for suicide. There are many reasons why a consumer may consider suicide and the answers to these questions can assist a Care Manager in making an appropriate referral for medical or psychiatric intervention.

Question 1: Have you thought about hurting yourself or taking your life in the PAST 30 DAYS?

Select No, Yes or Individual Refused to Answer. If Yes, complete questions 2 and 3 (Aging Suicide Risk Assessment).

Question 2: When did you have these thoughts, and do you have a plan to take your life?

Select No, Yes or Individual Refused to Answer. If Yes, Document Details in Notes section.

Question 3: Have you ever had a suicide attempt?

Select No, Yes or Individual Refused to Answer. If Yes, Document Details in Notes section.

8. BEHAVIORS - MANDATORY if Neurological, I/DD or Psychiatric Diagnosis
8.A. BEHAVIORS

Question 1: Does the individual present with any BEHAVIORAL signs/ symptoms? This Section is REQUIRED if any Neurologic, IDD or Psychiatric Diagnoses were noted in Section 5, 6 or 7.

Select No, Yes or Unable to Determine. If No, Skip to 8.B.1. If Yes or Unable to Determine, Complete ALL of Section 8.

Question 2a: Does the individual exhibit PHYSICAL behavioral symptoms toward OTHERS?

Select No or Yes. If No, Skip to 8.A.3a. If Yes, Complete 8.A.2b and 2c.

Question 2b: Specify ALL types of aggressive PHYSICAL behavior toward OTHERS (If not listed, document in Notes.)

Select appropriate response(s). If not listed, select “Other” and Document Details in Notes section.

Question 2c: Does the aggressive PHYSICAL behavior toward OTHERS interfere with the individual’s ability to function daily?

Select No or Yes. If No, document why the behavior does NOT interfere in the Notes section. If Yes, document how the behavior interferes in the Notes section.

Question 3a: Does the individual exhibit aggressive PHYSICAL behavioral symptoms towards SELF?

Select No or Yes. If No, Skip to 8.A.4a. If Yes, Complete 8.A.3b and 3c.

Question 3b: Specify ALL types of aggressive PHYSICAL behavior towards SELF (If not listed, document in Notes.)

Select appropriate response(s). If not listed, select “Other” and Document Details in Notes section.

Question 3c: Does the aggressive PHYSICAL behavior toward SELF interfere with the individual's ability to function daily?

Select No or Yes. If No, document why the behavior does NOT interfere in the Notes section. If Yes, document how the behavior interferes in the Notes section.

Question 4a: Does the individual exhibit aggressive VERBAL behavior symptoms toward OTHERS?

Select No or Yes. If No, Skip to 8.A.5a. If Yes, Complete 8.A.4b and 4c.

Question 4b: Specify ALL types of aggressive VERBAL behavior towards OTHERS (If not listed, document in Notes.)

Select appropriate response(s). If not listed, select "Other" and Document Details in Notes section.

Question 4c: Does the aggressive VERBAL behavior toward OTHERS interfere with the individual's ability to function daily?

Select No or Yes. If No, document why the behavior does NOT interfere in the Notes section. If Yes, document how the behavior interferes in the Notes section.

Question 5a: Does the individual exhibit any GENERAL aggressive VERBAL behavior symptoms not specifically directed toward self or others?

Select No or Yes. If No, Skip to 8.A.6a. If Yes, Complete 8.A.5b and 5c.

Question 5b: Select ALL GENERAL aggressive VERBAL behaviors (If not listed, document in Notes.)

Select appropriate response(s). If not listed, select "Other" and Document Details in Notes section.

Question 5c: Does the GENERAL aggressive VERBAL behavior interfere with the individual's ability to function daily?

Select No or Yes. If No, document why the behavior does NOT interfere in the Notes section. If yes, document how the behavior interferes in the Notes section.

Question 6a: Does the individual exhibit any OTHER behavioral symptoms?

Select No or Yes. If No, Skip to 8.B.1. If Yes, Complete 8.A.6b and 6c.

Question 6b: Specify ALL OTHER types of behaviors reported (If not listed, document in Notes).

Select appropriate response(s). If not listed, select "Other" and Document Details in Notes section.

Question 6c: Do the OTHER types of behaviors interfere with the individual's ability to function daily?

Select No or Yes. If No, document why the behavior does NOT interfere in the Notes section. If yes, document how the behavior interferes in the Notes section.

8.B. ADDICTIVE BEHAVIORS

The following questions will assist a Care Manager in identifying if a consumer has a drug or alcohol problem and lead to conversation about treatment.

Question 1: Has anyone ever expressed concern about your use of alcohol or drugs?

Select No or Yes. If No, Skip to Section 9.A.1. If Yes, Complete Section 8.B. and Document Details in Notes section.

Question 2: Do you find yourself missing work, family events, activities that you once participated in due to over use of a substance?

Select No or Yes. If Yes, Document Details in Notes section.

Question 3: Is drinking or use of other substances making your home life unhappy?

Select No or Yes. If Yes, Document Details in Notes section.

Question 4: Do you find yourself reaching for an alcoholic drink or other substance to get you through an event or interaction with certain people?

Select No or Yes. If Yes, Document Details in Notes section.

Question 5: Do you drink or use other substances alone? (Do you live alone? Feel lonely?)

Select No or Yes. If Yes, Document Details in Notes section.

Question 6: Have you ever felt remorse (regret) after you've drank or used other substance?

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Select No or Yes. If Yes, Document Details in Notes section.

Question 7: Do you believe that your drinking or use of other substances is causing a financial burden or decline?

Select No or Yes. If Yes, Document Details in Notes section.

Question 8: Do you find your ambition (effort to get up and do things each day) has declined since drinking or using other substances?

Select No or Yes. If Yes, Document Details in Notes section.

Question 9: Do you find yourself replacing meals with either an alcoholic drink or another substance?

Select No or Yes. If Yes, Document Details in Notes section.

Question 10: Does drinking or use of other substances cause you to have difficulty sleeping?

Select No or Yes. If Yes, Document Details in Notes section.

Question 11: Do you drink to escape (getaway from) worries or troubles?

Select No or Yes. If Yes, Document Details in Notes section.

Question 12: Do you find yourself more depressed since drinking or using other substances?

Select No or Yes. If Yes, Document Details in Notes section.

Question 13: Are you having memory problems due to drinking or use of substances?

Select No or Yes. If Yes, Document Details in Notes section.

Question 14: Have you spoken to your doctor about drinking or use of other substances?

Select No or Yes. If Yes, Document Details in Notes section.

Question 15: Have you ever been treated in a hospital, rehabilitation center or by a doctor for drinking or other substance use?

Select No or Yes. If Yes, Document Details in Notes section.

9. OTHER MEDICAL INFORMATION
9.A. SUPERVISION

Question 1: Has the individual exhibited ELOPEMENT behavior in the LAST 6 MONTHS? If so, indicate the FREQUENCY:

Select one response. If "Other", Document Details in Notes section.

Question 2a: Does the individual require supervision? Document Details in Notes:

Select No or Yes. If No, Skip to 9.A.4. If Yes, Complete 9.A.

Question 2b: How long can the individual be routinely left alone? Document Details in Notes:

Select one response. Document Details in Notes section.

Question 3: Why does the individual require supervision? Document Details in Notes:

Select appropriate response(s). If not listed, select "Other" and Document Details in Notes section. For all other responses, document the reason(s) why the individual needs the type and duration of supervision in the Notes section.

Question 4: Can the individual evacuate their home in the event of a fire?

Select No or Yes. If No, See Section 17 Emergency Information. Document Details in the Notes section.

9.B. FRAILTY SCORE

Someone is considered frail if they meet 3 or more of 5 criteria: weight loss, exhaustion, weak grip strength, slow walking speed and low physical activity. The following simple test measures frailty. If the individual has 3 underlined responses to the following questions they meet the definition of frail.

Question 1: Are you tired?

Select No or Yes.

Question 2: Can you walk up a flight of stairs?

Select No or Yes.

Question 3: Can you walk a city block (250-350 feet)?

Select No or Yes.

Question 4: Do you have more than 5 illnesses?

Select No or Yes.

Question 5: Have you lost more than 5% of your weight in the last year?

Select No or Yes.

Question 6: Individual shows symptoms of being frail?

Frailty score: 3 of 5 indicators = frail
A true or false response will be generated by the algorithm.

9.C. DEPRESSION/LIFE SATISFACTION

When the individual has 3 or more underlined responses they have an indicator for depression. Depression in older individuals increases the likelihood of hospitalization or nursing facility placement.

Question 1: Are you basically satisfied with your life?

Select No or Yes.

Question 2: Do you often get bored?

Select No or Yes.

Question 3: Do you often feel hopeless?

Select No or Yes.

Question 4: Do you prefer to stay at home, rather than going out and doing new things?

Select No or Yes.
Question 5: Do you ever have feelings of worthlessness?

Select No or Yes.

Question 6: Individual shows symptoms of being depressed?

Depression/Life Satisfaction score: 3 of 5 indicators = possible depression

A true or false response will be generated by the algorithm.

9.D. MEDICATION MANAGEMENT

The purpose of this section is to document the name of medication(s) prescribed, dose, type, route, and frequency. It also describes the individual's ability to manage medication.

Over the Counter (OTC) Medications are recorded under OTC Medications unless the individual is in a facility then it is recorded under Prescribed Medications. When assessing an individual in a facility, evaluate the **ability** of the individual to administer medications, not what is occurring in the facility.

Question 1: Does the individual take any PRESCRIBED Medications?

Select No or Yes. If No, Skip to 9.D.6.

Question 2: Does the individual have a central venous line?

Select No or Yes. If Yes, document the type and Details in Notes section.

Question 3: List all PRESCRIBED medications taken by the individual:

The Care Manager will document:

- The Name and Dose of the medication
- The Unit type
- The Form
- The Frequency

Question 4: Does the individual take all medications as prescribed?

Select No or Yes. If No, Document Details in Notes section.

Question 5: Does the individual know what medication they take and why? Document Details in Notes:

Select No, Yes, or Unable to Determine. Document Details in Notes section.

Question 6: List all OVER THE COUNTER (OTC) medications taken by the individual:

The Care Manager will document:

- The Name and Dose of the medication
- The Unit type
- The Form
- The Frequency

Question 7: Does the individual have any allergies or adverse reactions to any medication?

Select No or Yes. If Yes, Document Details in Notes section.

Question 8: What is the individual's ability level to manage medication?

Select one response. If Independent, Skip to 9.D.11.

Question 9: If Limited Assistance, indicate ALL types needed for MEDICATION MANAGEMENT:

Select appropriate response(s). If not listed, select "Other" and Document Details in Notes section.

Question 10: Who assists the individual with medication administration?

Select appropriate response(s). Document Details in Notes section.

Question 11: Does the individual need additional assistance in managing Medications, OR is this need currently addressed in their OPTIONS care plan?

Select No or Yes. If Yes, Document Details in Notes section. If the answer to either part of the question is YES, select YES. Additionally, if the individual's care plan includes a **formal** OPTIONS service addressing the identified need, the Care Manager will select YES.

Question 12: Does the individual use herbs or other remedies?

Select No or Yes. If Yes, Document Details in Notes section.

Question 13: Pharmacy Information (Name, Phone, etc.)

Document the individual's pharmacy information including name, address, and phone number.

9.E. HEIGHT/WEIGHT

It is important for a Care Manager to know if the individual has lost or gained 10 pounds or more in the past 6 months. This could indicate an underlying illness or eating disorder.

Some prompting questions for weight loss or gain: Have you recently (last six months) lost or gained weight without any changes to your diet or exercise? Do you know why your weight has gone up or down?

Question 1: What is the individual's height?

Document the height of the individual.

Question 2: What is the individual's weight?

Document the individual's weight.

Question 3: Document the reason(s) for weight gain or loss (See 13.B.10):

Select the correct response. If not listed, select "Other" and document the reason in the Notes section.

Question 4: Is physician aware of the weight change?

Select No or Yes.

Question 5: What is the individual's weight type?

Select one response. Utilize the BMI calculation to determine weight type.
http://www.nhlbi.nih.gov/guidelines/obesity/BMI/bmicalc.htm

9.F. PAIN

This section addresses if an individual is experiencing pain, the location, level and frequency of the pain, and whether the pain is impacting their ability to function daily.

Question 1: Does the individual report PAIN?

Select No, Yes or Unable to Determine. If No or Unable to Determine, Skip to 10.A.1a.

Question 2: Location(s) of PAIN site(s):

Select appropriate response(s). If not listed, select "Other" and Document Details in Notes section.

Question 3: Indicate the level of PAIN the individual reports using a scale from 0-10 (0=no pain, 10=severe pain):

Select appropriate response to indicate the level of pain the individual is experiencing.

Question 4: Indicate the frequency the individual reports the PAIN:

Select appropriate response to indicate how frequent the individual has pain and Document Details in Notes section.

Question 5: Select all the current treatments for PAIN diagnoses:

Select appropriate response(s). If Medications is selected, List in 9.D. If treatment is not listed, select "Other" and Document Details in Notes section.

Question 6: Pain Management:

If the individual has no pain treatment, select "No pain treatment". Select the appropriate response to the individual's pain relief after treatment and Document Details in Notes section.

Question 7: Does PAIN affect the individual's ability to function?

Select No or Yes. If Yes, Document Details in Notes section.

Question 8: Who manages care of the PAIN condition(s)?

Select appropriate response(s) for who manages care of the condition. If not listed, select "Other" and Document Details in Notes section.

Question 9: Does the individual need additional assistance in managing PAIN, OR is this need currently addressed in their OPTIONS care plan?

Select No or Yes. If Yes, Document Details in Notes section. If the answer to either part of the question is YES, select YES. Additionally, if the individual's care plan includes a **formal** OPTIONS service addressing the identified need, the Care Manager will select YES.

10. ACTIVITIES OF DAILY LIVING (ADLs)

The Care Manager will assess the individual's ability to perform their ADLs and the ability to manage them with reasonable safety. There may be instances in which the individual has no opportunity to perform ADL tasks because they may already be in a facility, a hospital, or family members are assisting. Therefore, in order to accurately assess the individual's ability to perform any ADLs, the Care Manager is required to review facility charts in addition to asking the individual and evaluating their abilities.

ADL's include:

- Bathing
- Dressing

- Grooming
- Eating
- Transferring
- Toileting
- Bladder/Bowel Incontinence
- Walking

NOTE: If “Total Assistance” is selected for any ADL, skip forward to the next appropriate question, as designated in the NAT.

Independent: The ability to completely manage the ADL without assistance. If an individual can manage the ADL on their own, including the use of an assistive device, they are independent. For example, an individual sits on a shower seat and uses a hand held showerhead to bathe. Assistance with these devices or any other aspects of bathing is not required. The Care Manager will make a note within the response of “Independent”, listing any assistive devices the individual uses in order to complete the ADL independently.

Limited Assistance: Some assistance is required for the individual to complete the ADL. For example, an individual sits on a shower seat and uses a hand held showerhead to bathe. The individual has limited range of motion in their arm because of a shoulder replacement surgery and arthritis. They require assistance with handling and maneuvering the showerhead in order to wash themselves. Select the response(s) in the drop down menu that best describes what assistance is being provided.

- Guided Maneuvers: Hands-on assistance or weight-bearing support is required while performing ADL’s.

Total Assistance: Full assistance of another individual is required to perform the ADL.

Document Details in Notes section when additional information is provided.

10.A. Bathing

Question 1a: BATHING: Ability to prepare a bath and wash oneself, including turning on the water, regulating temperature, etc.

Select appropriate response. If Independent, Skip to 10.B.1a. If Total Assistance, Skip to 10.A.1c.

Question 1b: If Limited Assistance, indicate ALL types needed for BATHING:

Select appropriate response(s). If “Other”, Document Details in Notes section.

Question 1c: BATHING: Assistance currently provided by what INFORMAL supports? Document Details in Notes:

Select appropriate response(s). Document Details in Notes section.

Question 1d: BATHING: Assistance currently provided by what FORMAL supports? Document Details in Notes:

Select appropriate response(s). Document Details in Notes section.

Question 1e: How often is BATHING support available? Document Details in Notes:

Select appropriate response. If "Other", Document Details in Notes section.

Question 1f: Type of BATHING? Document Details in Notes:

Select appropriate response(s). Document Details in Notes section.

Question 1g: Assistive devices/ adaptive equipment used for BATHING? Document Details in Notes:

Select appropriate response(s). If assistive device/adaptive equipment are used, Document Details in Notes section.

Question 1h: Does the individual need additional assistance in managing BATHING, OR is the need currently addressed in their OPTIONS care plan?

Select No or Yes. If Yes, Document Details in Notes section. If the answer to either part of the question is YES, select YES. Additionally, if the individual's care plan includes a **formal** OPTIONS service addressing the identified need, the Care Manager will select YES.

10.B Dressing

Question 1a: DRESSING: Ability to remove clothes from a closet/ drawer; application of clothing; including shoes/ socks (regular/ TEDS); orthotics; prostheses; removal/ storage of items; managing fasteners; and to use any needed assistive devices.

Select appropriate response. If Independent, Skip to 10.C.1a. If Total Assistance, Skip to 10.B.1c.

Question 1b: If Limited Assistance, indicate ALL types needed for DRESSING:

Select appropriate response(s). If "Other", Document Details in Notes section.

Question 1c: DRESSING: Assistance currently provided by what INFORMAL supports? Document Details in Notes:

Select appropriate response(s). Document Details in Notes section.

Question 1d: DRESSING: Assistance currently provided by what FORMAL supports? Document Details in Notes:

Select appropriate response(s). Document Details in Notes section.

Question 1e: How often is DRESSING support available? Document Details in Notes:

Select appropriate response. If "Other", Document Details in Notes section.

Question 1f: Assistive devices/adaptive equipment used for DRESSING? Document Details in Notes:

Select appropriate response(s). If assistive device/adaptive equipment are used, Document Details in Notes section.

Question 1g: Does the individual need additional assistance in managing DRESSING, OR is this need currently addressed in their OPTIONS care plan?

Select No or Yes. If Yes, Document Details in Notes section. If the answer to either part of the question is YES, select YES. Additionally, if the individual's care plan includes a **formal** OPTIONS service addressing the identified need, the Care Manager will select YES.

10.C. Grooming

Question 1a: GROOMING/PERSONAL HYGIENE: Ability to comb/ brush hair; brush teeth; care for/ insert dentures; shave; apply make-up (if worn); apply deodorant, etc.

Select appropriate response. If Independent, Skip to 10.D.1a. If Total Assistance, Skip to 10.C.1c.

Question 1b: If Limited Assistance, indicate ALL types needed for GROOMING/ PERSONAL HYGIENE:

Select appropriate response(s). If "Other", Document Details in Notes section.

Question 1c: GROOMING/PERSONAL HYGIENE: Assistance currently provided by what INFORMAL supports? Document Details in Notes:

Select appropriate response(s). Document Details in Notes section.

Question 1d: GROOMING/PERSONAL HYGIENE: Assistance currently provided by what FORMAL supports?

Select appropriate response(s). Document Details in Notes section.

Question 1e: How often is GROOMING/PERSONAL HYGIENE support available? Document Details in Notes:

Select appropriate response. If “Other”, Document Details in Notes section.

Question 1f: Are assistive devices/adaptive equipment used for GROOMING/ PERSONAL HYGIENE? Document Details in Notes:

Select appropriate response(s). If assistive device/adaptive equipment are used, Document Details in Notes section.

Question 1g: Does the individual need additional assistance in managing GROOMING, OR is this need currently addressed in their OPTIONS care plan?

Select No or Yes. If Yes, Document Details in Notes section. If the answer to either part of the question is YES, select YES. Additionally, if the individual’s care plan includes a **formal** OPTIONS service addressing the identified need, the Care Manager will select YES.

10.D. Eating

Question 1a: EATING: Ability to eat/drink; cut, chew, swallow food; and to use any needed assistive devices:

Select appropriate response. If Independent, Skip to 10.E.1a. If Does not eat is selected, Skip to 10.D.1c. If Total Assistance, Skip to 10.D.1c.

Question 1b: If Limited Assistance, indicate ALL types needed for EATING:

Select appropriate response(s). If “Other”, Document Details in Notes section.

Question 1c: If response to 10.A.4a is "4-Does not eat", indicate type of nutritional intake. Check ALL that apply:

Select appropriate response(s). If “Other”, Document Details in Notes section.

Question 1d: EATING: Assistance currently provided by what INFORMAL supports? Document Details in Notes:

Select appropriate response(s). Document Details in Notes section.

Question 1e: EATING: Assistance currently provided by what FORMAL supports?

Select appropriate response(s). Document Details in Notes section.

Question 1f: How often is EATING support available? Document Details in Notes:

Select appropriate response. If “Other”, Document Details in Notes section.

Question 1g: Assistive devices/adaptive equipment used for EATING? Document Details in Notes:

Select appropriate response(s). If assistive device/adaptive equipment are used, Document Details in Notes section.

Question 1h: Does the individual need additional assistance in managing EATING, OR is this need currently addressed in their OPTIONS care plan?

Select No or Yes. If Yes, Document Details in Notes section. If the answer to either part of the question is YES, select YES. Additionally, if the individual’s care plan includes a **formal** OPTIONS service addressing the identified need, the Care Manager will select YES.

10.E. Transfer

Question 1a: TRANSFER: Ability to move between surfaces, including to/ from bed, chair, wheelchair, or to a standing position; onto or off a commode; and to manage/ use any needed assistive devices.

Select appropriate response. If Independent, Skip to 10.F.1a. If Total Assistance, Skip to 10.E.1c.

Question 1b: If Limited Assistance, indicate ALL types needed for TRANSFER:

Select appropriate response(s). If “Other”, Document Details in Notes section.

Question 1c: TRANSFER: Assistance currently provided by what INFORMAL supports? Document Details in Notes:

Select appropriate response(s). Document Details in Notes section.

Question 1d: TRANSFER: Assistance currently provided by what FORMAL supports?

Select appropriate response(s). Document Details in Notes section.

Question 1e: How often is support available for TRANSFER? Document Details in Notes:

Select appropriate response. If "Other", Document Details in Notes section.

Question 1f: Assistive devices/adaptive equipment used for TRANSFER? Document Details in Notes:

Select appropriate response(s). If assistive device/adaptive equipment are used, Document Details in Notes section.

Question 1g: Does the individual need additional assistance in managing TRANSFERS, OR is this need currently addressed in their OPTIONS care plan?

Select No or Yes. If Yes, Document Details in Notes section. If the answer to either part of the question is YES, select YES. Additionally, if the individual's care plan includes a **formal** OPTIONS service addressing the identified need, the Care Manager will select YES.

10.F. Toileting

Question 1a: TOILETING: Ability to manage bowel and bladder elimination:

Select appropriate response. If Independent, Skip to 10.G.1a. If Total Assistance, Skip to 10.F.1c.

Question 1b: If Limited Assistance, indicate ALL types needed for TOILETING:

Select appropriate response(s). If "Other", Document Details in Notes section.

Question 1c: TOILETING: Assistance currently provided by what INFORMAL supports? Document Details in Notes:

Select appropriate response(s). Document Details in Notes section.

Question 1d: TOILETING: Assistance currently provided by what FORMAL supports?

Select appropriate response(s). Document Details in Notes section.

Question 1e: How often is support available for TOILETING? Document Details in Notes:

Select appropriate response. If “Other”, Document Details in Notes section.

Question 1f: Assistive devices/adaptive equipment used for TOILETING? Document Details in Notes:

Select appropriate response(s). If assistive device/adaptive equipment are used, Document Details in Notes section.

Question 1g: Does the individual need additional assistance in managing TOILETING, OR is this need currently addressed in their OPTIONS care plan?

Select No or Yes. If Yes, Document Details in Notes section. If the answer to either part of the question is YES, select YES. Additionally, if the individual’s care plan includes a **formal** OPTIONS service addressing the identified need, the Care Manager will select YES.

10.G. Bladder and Bowel Continence

Question 1a: BLADDER CONTINENCE: Indicate the description that best describes the individual's BLADDER function:

Select appropriate response.

Question 1b: Does the individual need additional assistance in managing BLADDER, OR is this need currently addressed in their OPTIONS care plan?

Select No or Yes. If Yes, Document Details in Notes section. If the answer to either part of the question is YES, select YES. Additionally, if the individual’s care plan includes a **formal** OPTIONS service addressing the identified need, the Care Manager will select YES.

Question 1c: BOWEL CONTINENCE: Indicate the description that best describes the individual's BOWEL function:

Select appropriate response.

Question 1d: Does the individual need additional assistance in managing BOWELS, OR is this need currently addressed in their OPTIONS care plan?

Select No or Yes. If Yes, Document Details in Notes section. If the answer to either part of the question is YES, select YES. Additionally, if the individual's care plan includes a **formal** OPTIONS service addressing the identified need, the Care Manager will select YES.

Question 1e: Does the individual use incontinency products?

Select No or Yes. If Yes, Document Details in Notes section.

10.H. Walking

Question 1a: WALKING: Ability to safely walk to/ from one area to another; manage/ use any needed ambulation devices:

Select appropriate response. If Independent, Skip to 11.A.1. If Total Assistance, Skip to 10.A.8c.

Question 1b: If Limited Assistance, indicate ALL types needed for WALKING:

Select appropriate response(s). If "Other", Document Details in Notes section.

Question 1c: Does the individual need additional assistance in managing WALKING, OR is this need currently addressed in their OPTIONS care plan?

Select No or Yes. If Yes, Document Details in Notes section. If the answer to either part of the question is YES, select YES. Additionally, if the individual's care plan includes a **formal** OPTIONS service addressing the identified need, the Care Manager will select YES.

11. MOBILITY
11.A. INDIVIDUAL'S MOBILITY

The Care Manager will choose the appropriate response for each question regarding mobility status that best describes the individual's ability to perform each task.

- Guided Maneuvers: An individual who requires hands on assistance or requires weight-bearing support while performing ADLs.

Needs Assessment Tool Form Instructions

The Care Manager will evaluate an individual's mobility through observation and questioning. If the individual consents, the Care Manager will ask for a demonstration of mobility.

Question 1: BEDBOUND: Is the individual bedbound? Indicate in Notes any comments or relevant information:

Select appropriate response. If Yes, Skip to 12.A.1. Document Details in Notes section.
An individual who never leaves the bed is considered bedbound.

Question 2a: INDOOR MOBILITY: Ability of movement within INTERIOR environment:

Select appropriate response. Document Details in Notes section. If Independent, Skip to 11.A.3a.

Question 2b: If Limited Assistance, indicate ALL types needed for INDOOR MOBILITY:

Select appropriate response(s). If "Other", Document Details in Notes section.

Question 2c: Assistive devices needed for INDOOR MOBILITY. Document Details in Notes:

Select appropriate response(s). If assistive device(s) are used, Document Details in Notes section.

Question 2d: Does the individual need additional assistance in managing INDOOR MOBILITY, OR is this need currently addressed in their OPTIONS care plan?

Select No or Yes. If Yes, Document Details in Notes section. If the answer to either part of the question is YES, select YES. Additionally, if the individual's care plan includes a **formal** OPTIONS service addressing the identified need, the Care Manager will select YES.

Question 3a: OUTDOOR MOBILITY: Ability of movement OUTSIDE living arrangement:

Select appropriate response. Document Details in Notes section. If Independent, Skip to 11.A.4a.

Needs Assessment Tool Form Instructions

Question 3b: If Limited Assistance, indicate ALL types needed for OUTDOOR MOBILITY:

Select appropriate response(s). If “Other”, Document Details in Notes section.

Question 3c: Assistive devices needed for OUTDOOR MOBILITY

Select appropriate response(s). If assistive device(s) are used, Document Details in Notes section.

Question 3d: Does the individual need additional assistance in managing OUTDOOR MOBILITY, OR is this need currently addressed in their OPTIONS care plan?

Select No or Yes. If Yes, Document Details in Notes section. If the answer to either part of the question is YES, select YES. Additionally, if the individual’s care plan includes a **formal** OPTIONS service addressing the identified need, the Care Manager will select YES.

Question 4a: STAIR MOBILITY: Movement safely up and down STEPS:

Select appropriate response. Document Details in Notes section. If Independent, Skip to 11.A.5.

Question 4b: If Limited Assistance, indicate ALL types needed for STAIR MOBILITY:

Select appropriate response(s). If “Other”, Document Details in Notes section.

Question 4c: Does the individual need additional assistance in managing STAIRS, OR is this need currently addressed in their OPTIONS care plan?

Select No or Yes. If Yes, Document Details in Notes section. If the answer to either part of the question is YES, select YES. Additionally, if the individual’s care plan includes a **formal** OPTIONS service addressing the identified need, the Care Manager will select YES.

Question 5: What is the individual's weight bearing status?

Select appropriate response. If Unable to determine, Document Details in Notes section.

Needs Assessment Tool Form Instructions

NOTE: “Weight bearing” refers to the ability to put weight on the lower extremities.

Full Weight Bearing (FWB): The individual is able to place full body weight on the affected leg(s) when standing or walking. No limitations.

Partial Weight Bearing (PWB): The individual is able to place a percentage of body weight on the affected leg(s) when standing or walking. **NOTE:** These numbers are designated by a physician or therapist.

Toe-touch Weight Bearing (TTWB): The individual is able to touch the floor only for balance when standing or walking and does not place actual weight on the affected leg(s).

Non-weight Bearing (NWB): The individual is unable to place any weight on affected leg(s) or touch the floor with the affected leg(s).

Question 6: Select all that affect the individual's MOBILITY:

Select appropriate response(s). If “Other”, Document Details in Notes section.

11.B. FALLS

An individual may be at risk for falls due to poor or declining health, impaired balance, decreased strength and/or flexibility, visual impairment, and medications. The Care Manager will make a judgment, regarding the individual’s risk for falls, based on observations and information provided by the individual or informal supports.

Care Managers will ask prompting questions to determine an individual’s history and risk for falls. Questions will include: Have you fallen during the past six months? How often? Where did you fall? What were you doing at the time? Did you faint or lose consciousness? Were you injured in the fall(s)? Could you get back up by yourself? Did a physician see you or did you go to the emergency room to be evaluated after your fall? Do you do anything special to prevent falls?

Question 1: Is the individual at risk of falling?

Select appropriate response. Document Details in the Notes section. Clearly document the individual’s functional deficit(s) related to their diagnoses which puts them at risk.

Question 2: Select the number of times the individual has fallen in the LAST 6 MONTHS.

Select appropriate response. If None, Skip to 12.A.1.

Question 3: Reasons for falls – Document Details in Notes

Select appropriate response. Document Details in Notes section.

12. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)
12.A. IADLs

IADLs include meal preparation, housework, laundry, shopping, using transportation, money management, using the telephone and home maintenance activities. Performing IADLs requires a combination of memory, judgement, and physical ability. Assessing the individual's ability to perform IADL tasks can help a Care Manager identify physical and cognitive limitations.

When administering the IADL questions, it is very important for the Care Manager to assess the ability of the individual to perform the task rather than how the task is currently completed. Document in the Notes section how the task is being completed.

Question 1: MEAL PREPARATION: Ability to plan/ prepare meals, use of kitchen appliances, heat meals. List any needed adaptive equipment/ assistive devices in Notes:

Select appropriate response. If Independent, Skip to 12.A.2. Document Details in Notes section.

Question 1a: MEAL PREPARATION: Assistance is currently provided by what INFORMAL supports? Document Details in Notes:

Select appropriate response(s). Document Details in Notes section.

Question 1b: MEAL PREPARATION: Assistance is currently provided by what FORMAL supports? Document Details in Notes:

Select appropriate response(s). Document Details in Notes section.

Question 1c: How often is support available for MEAL PREPARATION? Document Details in Notes:

Select appropriate response. If "Other", Document Details in Notes section.

Question 1d: Does the individual need additional assistance in managing MEALS, OR is this need currently addressed in their OPTIONS care plan?

Select No or Yes. If Yes, Document Details in Notes section. If the answer to either part of the question is YES, select YES. Additionally, if the individual's care plan includes a **formal** OPTIONS service addressing the identified need, the Care Manager will select YES.

Question 2: HOUSEWORK: Ability to maintain living space, includes tasks such as dishwashing, making the bed, dusting, running the vacuum or sweeping an area. List any needed adaptive equipment/ assistive devices in Notes.

Select appropriate response. If Independent, Skip to 12.A.3. Document Details in Notes section.

Question 2a: HOUSEWORK: Assistance is currently provided by what INFORMAL supports? Document Details in Notes:

Select appropriate response(s). Document Details in Notes section.

Question 2b: HOUSEWORK: Assistance is currently provided by what FORMAL supports? Document Details in Notes:

Select appropriate response(s). Document Details in Notes section.

Question 2c: How often is support available for HOUSEWORK? Document Details in Notes:

Select the appropriate response. If "Other", Document Details in Notes section.

Question 2d: Does the individual need additional assistance in managing LIGHT HOUSEWORK, OR is this need currently addressed in their OPTIONS care plan?

Select No or Yes. If Yes, Document Details in Notes section. If the answer to either part of the question is YES, select YES. Additionally, if the individual's care plan includes a **formal** OPTIONS service addressing the identified need, the Care Manager will select YES.

Question 3: LAUNDRY: Ability to gather clothes, place clothes in washing machine, turn on appliance, remove clothes and place in dryer, or hand wash items and hang to dry. List any needed adaptive equipment/ assistive devices in Notes:

Select appropriate response. If Independent, Skip to 12.A.4. Document Details in Notes section.

Question 3a: LAUNDRY: Assistance is currently provided by what INFORMAL supports? Document Details in Notes:

Select appropriate response(s). Document Details in Notes section.

Question 3b: LAUNDRY: Assistance is currently provided by what FORMAL supports? Document Details in Notes:

Select appropriate response(s). Document Details in Notes section.

Question 3c: How often is support available for LAUNDRY? Document Details in Notes:

Select appropriate response. If "Other", Document Details in Notes section.

Question 3d: Does the individual need additional assistance in managing LAUNDRY, OR is this need currently addressed in their OPTIONS care plan?

Select No or Yes. If Yes, Document Details in Notes section. If the answer to either part of the question is YES, select YES. Additionally, if the individual's care plan includes a **formal** OPTIONS service addressing the identified need, the Care Manager will select YES.

Question 4: SHOPPING: Ability to go to the store and purchase needed items, including groceries and other items. List any needed adaptive equipment/ assistive devices in Notes.

Select appropriate response. If Independent, Skip to 12.A.5. Document Details in Notes section.

Question 4a: SHOPPING: Assistance is currently provided by what INFORMAL supports? Document Details in Notes:

Select appropriate response(s). Document Details in Notes section.

Question 4b: SHOPPING: Assistance is currently provided by what FORMAL supports? Document Details in Notes:

Select appropriate response(s). Document Details in Notes section.

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Question 4c: How often is support available for SHOPPING? Document Details in Notes:

Select appropriate response. If “Other”, Document Details in Notes section.

Question 4d: Does the individual need additional assistance in managing SHOPPING, OR is this need currently addressed in their OPTIONS care plan?

Select No or Yes. If Yes, Document Details in Notes section. If the answer to either part of the question is YES, select YES. Additionally, if the individual’s care plan includes a **formal** OPTIONS service addressing the identified need, the Care Manager will select YES.

Question 5: TRANSPORTATION: Ability to travel on public transportation or drive a car. List any needed adaptive equipment/ assistive devices in Notes:

Select appropriate response. If Independent, Skip to 12.A.6. Document Details in Notes section.

Question 5a: TRANSPORTATION: Assistance is currently provided by what INFORMAL supports? Document Details in Notes:

Select appropriate response(s). Document Details in Notes section.

Question 5b: TRANSPORTATION: Assistance is currently provided by what FORMAL supports? Document Details in Notes:

Select appropriate response(s). Document Details in Notes section.

Question 5c: How often is support available for TRANSPORTATION? Document Details in Notes:

Select appropriate response. If “Other”, Document Details in Notes section.

Question 5d: Does the individual need additional assistance in managing TRANSPORTATION, OR is this need currently addressed in their OPTIONS care plan?

Select No or Yes. If Yes, Document Details in Notes section. If the answer to either part of the question is YES, select YES. Additionally, if the individual’s care plan includes a **formal** OPTIONS service addressing the identified need, the Care Manager will select YES.

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Question 6: MONEY MANAGEMENT: Ability to manage financial matters, writing checks, paying bills, going to the bank. List any needed adaptive equipment/ assistive devices in Notes:

Select appropriate response. If Independent, Skip to 12.A.7. Document Details in Notes section.

Question 6a: MONEY MANAGEMENT: Assistance is currently provided by what INFORMAL supports? Document Details in Notes:

Select appropriate response(s). Document Details in Notes section.

Question 6b: MONEY MANAGEMENT: Assistance is currently provided by what FORMAL supports? Document Details in Notes:

Select appropriate response(s). Document Details in Notes section.

Question 6c: How often is support available for MONEY MANAGEMENT? Document Details in Notes:

Select appropriate response. If “Other”, Document Details in Notes section.

Question 6d: Does the individual need additional assistance in managing MONEY MANAGEMENT, OR is this need currently addressed in their OPTIONS care plan?

Select No or Yes. If Yes, Document Details in Notes section. If the answer to either part of the question is YES, select YES. Additionally, if the individual’s care plan includes a **formal** OPTIONS service addressing the identified need, the Care Manager will select YES.

Question 7: TELEPHONE: Ability to obtain phone numbers, dial the telephone and communicate with person on the other end. List any needed adaptive equipment/ assistive devices in Notes:

Select appropriate response. If Independent, Skip to 12.A.8. Document Details in the Notes section.

Question 7a: TELEPHONE: Assistance is currently provided by what INFORMAL supports? Document Details in Notes:

Select appropriate response(s). Document Details in Notes section.

Needs Assessment Tool Form Instructions

Question 7b: TELEPHONE: Assistance is currently provided by what FORMAL supports? Document Details in Notes:

Select appropriate response(s). Document Details in Notes section.

Question 7c: How often is support available for TELEPHONE? Document Details in Notes:

Select appropriate response. Document Details in Notes section.

Question 7d: Does the individual need additional assistance in managing TELEPHONE, OR is this need currently addressed in their OPTIONS care plan?

Select No or Yes. If Yes, Document Details in Notes section. If the answer to either part of the question is YES, select YES. Additionally, if the individual's care plan includes a **formal** OPTIONS service addressing the identified need, the Care Manager will select YES.

Question 8: HOME MANAGEMENT: Ability to perform heavier household tasks such as taking out the trash, completing minor repairs around the living space, yard work and/or snow removal. List any needed adaptive equipment/ assistive devices in Notes:

Select appropriate response. If Independent, Skip to 13.A.1. Document Details in Notes section.

Question 8a: HOME MANAGEMENT: Assistance is currently provided by what INFORMAL supports? Document Details in Notes:

Select appropriate response(s). Document Details in Notes section.

Question 8b: HOME MANAGEMENT: Assistance is currently provided by what FORMAL supports? Document Details in Notes:

Select appropriate response(s). Document Details in Notes section.

Question 8c: How often is support available for HOME MANAGEMENT? Document Details in Notes:

Select appropriate response. If "Other", Document Details in Notes section.

Question 8d: Does the individual need additional assistance in managing HOME MANAGEMENT, OR is this need currently addressed in their OPTIONS care plan?

Select No or Yes. If Yes, Document Details in Notes section. If the answer to either part of the question is YES, select YES. Additionally, if the individual's care plan includes a **formal** OPTIONS service addressing the identified need, the Care Manager will select YES.

13. NUTRITION
13.A. DIETARY ISSUES

Question 1: Does the individual generally have a good appetite?

Select appropriate response. If No or Other, Document Details in Notes section.

Question 2: Does the individual use a dietary supplement?

Select appropriate response. If Yes, Document Details in Notes section.

Question 3: Does the individual have any food allergies?

Select appropriate response. If Yes, Document Details in Notes section.

Question 4: Does the individual have a special diet for medical reasons?

Select appropriate response. If Yes, Document Details in Notes section.

Question 5: Does the individual have a special diet for religious/cultural reasons?

Select appropriate response. If Yes, Document Details in Notes section.

13.B. NUTRITIONAL RISK ASSESSMENT

Assessing an individual's nutritional need may assist the Care Manager in identifying any potential food insecurities such as the inability to obtain food or prepare meals due to a physical or cognitive disability, lack of resources (money) for meals or absence of someone willing or able to prepare meals.

Question 1: Has there been a change in lifelong eating habits because of health problems?

Select No or Yes. If Yes, Document Details in Notes section.

Question 2: Does the individual eat fewer than 2 meals per day?

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Select No or Yes. If Yes, Document Details in Notes section.

Question 3: Does the individual eat fewer than 2 servings of dairy products (such as milk, yogurt, or cheese) every day?

Select No or Yes. If Yes, Document Details in Notes section.

Question 4: Does the individual eat fewer than 5 servings (1/2 cup each) of fruits or vegetables every day?

Select No or Yes. If Yes, Document Details in Notes section.

Question 5: Does the individual have 3 or more drinks of beer, liquor or wine almost every day?

Select No or Yes. If Yes, Document Details in Notes section.

Question 6: Does the individual have trouble eating due to problems with chewing/ swallowing?

Select No or Yes. If Yes, Document Details in Notes section.

Question 7: Individual does not have enough money to buy food needed?

Select No or Yes. If No, Document Details in Notes section.

Question 8: Does the individual eat alone most of the time?

Select No or Yes. If Yes, Document Details in Notes section.

Question 9: Does the individual take 3 or more prescribed or over-the-counter (OTC) drugs per day?

Select No or Yes. If Yes, Document Details in Notes section.

Question 10: Has the individual lost or gained at least 10 pounds or more in the LAST 6 MONTHS? Document Details in NOTES (See 9.E.3)

Select appropriate response. If Yes, Document Details in Notes section.

QUESTION 11: Individual is not always physically able to shop, cook and/or feed themselves (or find someone to do it for them.)

Select No or Yes. If Yes, Document Details in Notes section.

Needs Assessment Tool Form Instructions

14. INFORMAL SUPPORTS
14.A. INFORMAL HELPER(S) INFORMATION

This section assists the Care Manager in determining the presence of a primary caregiver and may lead to the completion of the Caregiver Assessment Tool (CAT) to assess the caregiver's needs for the Caregiver Support Program (CSP).

Question 1: Does the individual have any NON-PAID helpers that provide care or assistance on a regular basis?

Select No or Yes. If No, Skip to 14.C.1. If Yes, Complete Section 14.

Question 2: List names, phone numbers and email addresses of the non-paid helpers. Use the Note section if more room is needed:

Document the non-paid helpers name(s), phone number(s) and email addresses.

Question 3: Do any of the non-paid helpers reside in the individual's home?

Select No or Yes. If Yes, Document Details in Notes section.

Question 4: Select the relationships of the individual's non-paid helpers:

Select the appropriate response(s). If "Other", Document Details in Notes section.

14.B. CONCERNS ABOUT THE HELPING RELATIONSHIPS

Question 1: What concerns does the individual have about any of the non-paid helpers? Document Details in Notes:

Select the appropriate response(s). If "Other", Document Details in Notes section.

NOTE: It is important to be aware that the individual may understate or overstate concerns based on the presence of caregivers during the assessment.

Question 2: Care Manager's observations or concerns about the non-paid helpers-Document Details in Notes:

Select the appropriate response(s). If "Other", Document Details in Notes section.

14.C. ADDITIONAL INFORMAL SUPPORTS

Question 1: Is the individual involved with any informal supports in the community that are or may be willing to provide help and support (e.g., church, social or community organizations)?

Select No or Yes. If No, Skip to 15.A.1. If Yes, Complete 14.C.2.

Question 2: Document the name of the community support(s), type of help and frequency of help that could be or is provided:

Document the name of the community support(s), type of help provided, and the frequency of help provided.

15. PROTECTIVE SERVICES (PS)

15.A. PROTECTIVE SERVICES (PS) Questions 1-3 are MANDATORY

Question 1: Does the individual feel afraid in his/ her current living situation?

Select No or Yes. If Yes, Complete Section 15.

Question 2: Is the individual safe to stay in his/ her home environment?

Select No or Yes. If No, Complete Section 15.

Question 3: Does the individual need a safe place to stay?

Select No or Yes. If Yes, Complete Section 15.

Question 4: Note any dangers - Document Details in Notes.

Select the appropriate response(s).

Question 5: Is a referral to protective services indicated?

Select No or Yes. If Yes, Document Details in Notes section.

15.B. ACCESS TO SERVICES

The Care Manager will document any barriers which may impact the individual's ability to access services identified in the care plan.

Question 1: Does the individual have an issue with access to needed services or supports?

Select No or Yes. If Yes, Document Details in Notes section.

Question 2: If the individual does not have access to the needed services or supports, what assistance is needed?

Needs Assessment Tool Form Instructions

Document the information for the assistance needed.

16. PHYSICAL ENVIRONMENT
16.A. CURRENT DWELLING UNIT

Question 1: Does the individual own his/ her current residence?

Select No or Yes. If No, Document Details in Notes section.

Question 2: Is the individual able to remain in his/ her current residence?

Select appropriate response. If No or Uncertain, Document Details in Notes section.

Question 3: What conditions of the home environment cause health and safety concerns to the individual? Document in Notes what and where are the problems.

Select appropriate response(s). If "Other", Document Details in Notes section.

Question 4: What areas of the home environment impact accessibility? Document in Notes, what and where problems exist.

Select appropriate response(s). If "Other", Document Details in Notes section.

17. EMERGENCY INFORMATION
17.A EMERGENCY INFORMATION

Question 1: What are the individual's physical limitations that would prevent individual leaving the home alone in an emergency?

Select appropriate response(s). If "Other", Document Details in Notes section.

Question 2: Does the individual have any of the following special medical needs during a public emergency?

Select appropriate response(s). If "Other", Document Details in Notes section.

Question 3: Select ALL types of Personal Emergency Response Systems (PERS) with which the individual is currently utilizing:

Select appropriate response(s). If "Other", Document Details in Notes section.

Question 4: Is the consumer enrolled in a community response program?

Select No or Yes. If Yes, Document Details in Notes section.

A community response program would include a program run by a local fire department or other local emergency response team.

18. EMERGENCY PLANNING
18.A. EMERGENCY PLANNING

In the event of an emergency, First Responders are called upon to assist individuals in need. By answering the following questions, the information gathered may be used to aid First Responders in identifying individuals who are at risk and can better coordinate efforts during the event.

Question 1: Is individual meal dependent?

Select Yes or No. If Yes, Document Details in Notes section.

An individual is considered to be meal dependent if they require the assistance of another individual to prepare or provide meals, or receive In-Home Meal Service.

Question 2: Is individual medication dependent?

Select Yes or No. If Yes, Document Details in Notes section.
An individual is considered medication dependent if they are prescribed medication(s) to manage a medical condition.

Question 3: Is individual electricity dependent?

Select Yes or No. If Yes, Document Details in Notes section.

An individual is considered electricity dependent if they require electricity to manage a medical condition, including but not limited to life-sustaining medical equipment.

Question 4: Is individual transportation dependent?

Select Yes or No. If Yes, Document Details in Notes section.

An individual is considered transportation dependent if they require the assistance of another individual to provide transportation.

Question 5: Is individual attendant dependent?

Select Yes or No. If Yes, Document Details in Notes section.

An individual is considered attendant dependent if they require assistance from another individual to manage ADLs or IADLs.

Question 6: Is oxygen dependent?

Select Yes or No. If Yes, Document Details in Notes section.

An individual is considered oxygen dependent if they require they require the use of oxygen.

Question 7: Is individual mobility dependent?

Select Yes or No. If Yes, Document Details in Notes section.

An individual is considered mobility dependent if they require the assistance of another individual or assistive device for mobility.

19. INDIVIDUAL/SPOUSE/HOUSEHOLD FINANCIAL DATA
19.A. INDIVIDUAL'S INCOME

For each income category listed in this section, note whether the individual received income in that category and the monthly amount.

Sometimes individuals will be reluctant to divulge information about income and assets. The Care Manager will assure them the information is strictly confidential, and will be used to determine eligibility for various programs and services.

Identify and record the individual's GROSS income. Bank statements will not be used to obtain financial information as bank statements often reflect net income after taxes and/or garnishments. Asset information is requested to determine if individuals' resources can be utilized in lieu of state funds.

Question 1: Refused to provide financial information?

Select No or Yes.

NOTE: Cost sharing requires the consumer to disclose income. If the consumer refuses to disclose this information, they will cost share at 100% or not receive any services which are cost shared.

Question 2: Does the individual have direct deposit?

Select No or Yes. If Yes, Document Details in Notes section.

Needs Assessment Tool Form Instructions

Question 3: Individual's monthly Social Security (SS) income:

Record this amount.

Question 4: Individual's monthly Supplemental Social Security Income (SSI):

Record this amount.

Question 5: Individual's monthly retirement/ pension income:

Record this amount.

Question 6: Individual's monthly interest/ dividends income:

Record this amount.

Question 7: Individual's monthly public assistance:

Record this amount.

Question 8: Individual's monthly wage/salary/earnings/self-employment income:

Record this amount.

Question 9: Individual's monthly net rental income:

Record this amount.

Question 10: Individual's monthly railroad retirement benefit income:

Record this amount.

Question 11: Individual's monthly annuity, trust, estate income:

Record this amount.

Question 12: Individual's other monthly income – Document the source of income in Notes:

Record this amount. Document Details in Notes section regarding the source of income.

Question 13: What is the individual's monthly income for alimony:

Record this amount.

Question 14: What is the consumer's monthly Medicare Part B premium:

Record this amount.

NOTE: This amount will be deducted from the gross Social Security income when the algorithm calculates the cost share percentage.

19.B. INDIVIDUAL'S ASSETS

Question 1: Individual's primary savings account balance:

Record the amount.

Question 2: Individual's primary checking account balance:

Record the amount.

Question 3: Individual's certificates/other retirement accounts:

Record the amount.

Question 4: Individual's NON-residential real estate assets value:

Record the amount.

Question 5: Cash surrender value of the individual's primary life insurance policy:

Record the amount.

Question 6: Individual's stocks and bonds account balances:

Record the amount.

Question 7: Individual's other account(s) balance(s)-Document type of account(s) in Notes:

Record the amount and document the types of accounts in the Notes section.

19.C. SPOUSE'S INCOME (Residing with Individual)

Question 1: Monthly Social Security (SS) income of spouse RESIDING with the individual:

Record this amount.

Question 2: Monthly SSI of spouse RESIDING with the individual:

Record this amount.

Question 3: Monthly retirement/ pension income of spouse RESIDING with the individual:

Record this amount.

Question 4: Monthly interest/ dividend income of spouse RESIDING with the individual:

Record this amount.

Question 5: Monthly public assistance income of spouse RESIDING with the individual:

Record this amount.

Question 6: Monthly wage/salary/earnings/self-employment income of spouse RESIDING with the individual:

Record this amount.

Question 7: Monthly net rental income of spouse RESIDING with the individual:

Record this amount.

Question 8: Other monthly income of spouse RESIDING with the individual- Document the source of income in Notes:

Record this amount and document the source of income in Notes section.

Question 9: What is the spouse's monthly alimony support:

Record this amount.

Question 10: What is the spouse's monthly Medicare Part B premium:

Record this amount.

NOTE: This amount will be deducted from the gross Social Security income when the algorithm calculates the cost share percentage.

19.D. HOUSEHOLD INCOME

Question 1: Cost Share Rate

The algorithm will calculate the cost share percentage.

Question 2: Enter Consumer's Cost Share Percentage from 18.D.1 above

Document the cost share percentage.

Question 3: Poverty Indicator

The algorithm will calculate the poverty indicator.

Question 4: Enter Consumer Poverty Indicator from 18.D.3 above. If NAT Consumer Poverty Indicator = 1, then check "Yes", if 0 check "No", if not calculated check "Don't Know".

Select appropriate box.

19.E. BENEFIT PROGRAMS

Question 1: Check all benefits the individual is currently RECEIVING:

Select appropriate response(s). If "Other", Document Details in Notes section.

Needs Assessment Tool Form Instructions

20. NEEDS ASSESSMENT SUMMARY
20.A. LCD & NAT OUTCOME

Question 1: Has level of care assessment been completed and individual determined Nursing Facility Clinically Eligible?

Select No or Yes.

Question 2: Has the individual had a change in condition that warrants a new Level of Care determination?

Select No or Yes. If Yes, Document Details in Notes section.

Question 3: Based on the NAT, what Locus of Care/Care Program is recommended:

Select appropriate response. If “Other”, Document Details in Notes section.

Department of Human Services’ programs include all Medical Assistance Long-Term Services and Supports Waivers, Act 150, and Community Health Choices (CHC).

QUESTION 4: NAS SCORE

The algorithm will calculate and populate a Needs Assessment Score (NAS).

QUESTION 5: What is the client’s total Needs Assessment Score (NAS), from 19.A.4., rounded to the nearest whole number:

Document the calculated NAS.

20.B. NEEDS ASSESSMENT OUTCOME AND AUTHENTICATION

All questions in the NAT will be completed before it is sent to the Supervisor for review. A NAT is not considered complete until the Supervisor has reviewed and selected Questions 5 and 6. A review of a NAT by an RN is not required, however, may be needed in the development of the care plan or as determined by the Care Manager and/or Supervisor. The signatures below indicate the NAT contains complete and accurate information.

Question 1: Name of Care Manager (CM)/Service Coordinator (SC) completing this Needs Assessment Tool:

Needs Assessment Tool Form Instructions

Document the Care Manager or Service Coordinator's first and last name.

Question 2: Date of Care Manager (CM)/Service Coordinator (SC) Signature:

Using the MM/DD/YYYY format, document the date the Care Manager or Service Coordinator signed the NAT.

Question 3: Name of Registered Nurse reviewing the Needs Assessment Tool (if reviewed):

Document the name of the Registered Nurse who reviewed the NAT.

Question 4: Date of Registered Nurse review (if reviewed):

Using the MM/DD/YYYY format, document the date the Registered Nurse reviewed the NAT.

Question 5: Name of Supervisor reviewing this Needs Assessment Tool:

Document the name of the Supervisor who reviewed and approved the NAT.

Question 6: Date Supervisor approved the Needs Assessment Tool:

Using the MM/DD/YYYY format, document the date the Supervisor reviewed the NAT.

Needs Assessment Tool Form Instructions

RESOURCES

4.B HEART/CIRCULATORY SYSTEMS

Ascites: An abnormal accumulation of fluid in the abdomen which results from high pressure in the blood vessels of the liver and low levels of a protein called albumin.

4.E. SKIN

Wound: A break in the continuity of soft parts of body structures caused by violence or trauma to tissues. It may be a result of an accident or disease. Wounds are not staged.

Ulcer: An open sore or lesion of the skin or mucous membrane accompanied by sloughing or inflamed necrotic tissue. Ulcers are usually caused by irritation as in the case of bedsores.

Unstageable Ulcer: A full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. The “base of the ulcer" is used to denote the inability to determine the depth.

Pressure Ulcer Staging is found on the last page for reference.

4.G. GENITOURINARY

Urinary incontinence almost always results from an underlying treatable medical condition. If an individual is incontinent of urine do not assume that it is caused by a bladder disorder such as neurogenic bladder, overactive bladder or urinary retention. Incontinence has many causes. Try to find out the underlying diagnosis that is causing the incontinence.

Neurogenic bladder dysfunction, sometimes simply referred to as neurogenic bladder, is a dysfunction of the urinary bladder due to disease of the central nervous system or peripheral nerves involved in the control of micturition (urination). Neurogenic bladder usually causes difficulty or full inability to pass urine without use of a catheter or other method.

7. MENTAL HEALTH

Mental illness is defined as a mental or bodily condition marked primarily by sufficient disorganization of personality, mind, and emotions to seriously impair the normal psychological functioning of the individual. The illness may result in a disruption in a person's thinking, feeling, moods and ability to relate to others.

Prompting questions: Have you ever seen a psychiatrist? Have you ever been told that you have any psychiatric problems? Did you receive treatment?

9. OTHER MEDICAL INFORMATION

Elopement: An individual who is cognitively, physically, mentally, emotionally, and/or chemically impaired; wanders away, walks away, runs away, escapes, or otherwise leaves their environment unsupervised or unnoticed.

9.B. FRAILTY

The term “frail” is intended to identify individuals at greatest risk of adverse outcomes including falls, worsening disability, institutionalization and death. Frailty is a term often used to label the condition of an older person who has health problems, has lost functional abilities and is likely to deteriorate further. It describes a health state that could occur as the result of a number of underlying health conditions.

9.D. MEDICATION MANAGEMENT

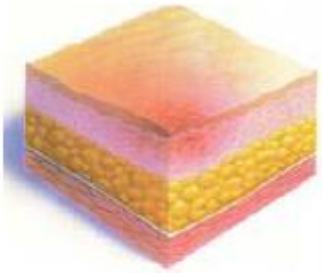
Central venous catheter ("central line", "CVC", "central venous line" or "central venous access catheter") is a long thin flexible catheter placed into a large vein in the neck (internal jugular vein), chest (subclavian vein or auxiliary vein) or groin (femoral vein) that is used to give medicines, fluids, nutrients, or blood products over a long period of time, take frequent blood samples, to receive kidney dialysis for kidney failure, give long-term medicine treatment for pain, infection, or cancer, or to supply nutrition. A central venous catheter can be left in place far longer than an intravenous catheter (IV).

Wound Consultants, Inc

Pressure Ulcer Staging

Stage I:

An observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.





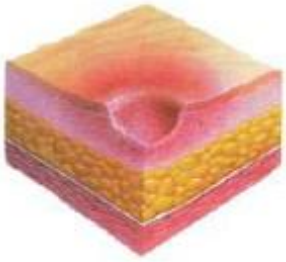


Stage II:

Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister or shallow crater.





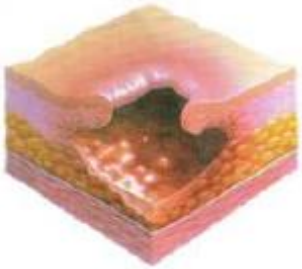






Stage III:

Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

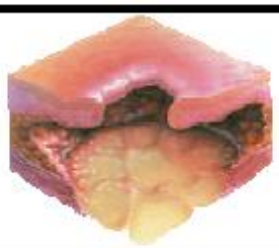






Stage IV:

Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g. tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.





Eschar

Thick dry black necrotic tissue – Unstageable





Needs Assessment Tool Form Instructions

Pressure Ulcer Staging

Descriptions as they appear in the visual example.

Stage 1: An observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.

Stage 2: Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister or shallow center.

Stage 3: Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

Stage 4: Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g. tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage 4 pressure ulcers.

Eschar: Thick dry black necrotic tissue – Unstageable