Needs Assessment Tool – Express Form Instructions

The Needs Assessment Tool – Express (NAT-E) is an assessment tool used for:

- Individuals in the OPTIONS Program receiving the service of Care Management alone or in combination with Emergent Services or In-Home Meals
- Individuals receiving congregate meals at a Senior Center, and
- Care Receivers in the Caregiver Support Program (CSP)

NOTE: For individuals receiving congregate meals at a Senior Center, only Section 1- Introduction and Section 2 – Nutrition of the NAT-E are required.

The information contained in the NAT-E is used to determine an individual's functional needs, strengths, resources, preferences, and goals in order to develop a person-centered care plan.

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

Medical conditions display drop-down boxes for each type of diagnosis. The category of "Other" for selections of diagnoses not provided and a Notes section for expanded documentation in each section is available. These questions are used to determine if a medical condition is present and if it affects the individual's ability to function.

To fully assess a consumer's needs, a NAT-E will be completed in person, in the consumer's home or at a congregate meal site. For congregate meals, the NAT-E can be used as a self-declaration tool.

The NAT-E is only considered complete for individuals enrolled in the OPTIONS Program and Care Receivers in CSP when all areas are addressed and the Supervisor has approved and signed off on the tool. If a Case Aide or trained intern completes the NAT-E, a review and sign-off by the supervising Care Manager is sufficient and meets this requirement.

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.

Needs Assessment Tool – Express Form Instructions

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.

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 12: Is the individual's annual income less than 100% of the current Federal Poverty Income Guidelines (FPIG)?

Select Yes, No or Unknown.

Question 13a: Does the individual have a Medicaid number?

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

Question 13b: Indicate Medicaid recipient number:

Enter the individual's Medicaid recipient number if applicable.

Question 14a: Does the individual have Medicare?

Select No or Yes. If yes, enter the number in 1.A.14b.

Question 14b: Indicate Medicare recipient number:

Enter the individual's Medicare recipient number if applicable.

Question 15a: Does the individual have any other insurance?

Select No, Yes or Don't Know. If yes, enter the number in 1.A.15b.

Question 15b: Indicate other health insurance information:

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

Question 16: Check all benefits the individual is currently RECEIVING:

Select all applicable responses.

1.B. NAT-E INFORMATION

Question 1: PSA Number:

Select the Agency PSA number.

Question 2: If NAT-E was completed for specific SERVICE(S), document ALL that apply.

Select all applicable responses.

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 NAT-E?

Select No or Yes. If No, complete 1.B.5 and why they did not participate 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. INDIVIDUAL'S DEMOGRAPHICS

Question 1a: Is the individual homeless?

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

***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.

***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.C.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.C.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.

Question 9: Is the consumer disabled?

Select No, Not Collected or Yes. If Not Collected, Document Details in Notes section.

1.D. 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.D & 1.E.

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.):

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.

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.

Needs Assessment Tool – Express Form Instructions

1.E. 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.F. EMERGENCY CONTACT

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. NUTRITION (Only Section 1 & 2 are required for Congregate Meals)

2.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.

2.B. NUTRITIONAL RISK ASSESSMENT

Assessing an individual's nutritional need may assist the Care Manager or designee 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?

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 Yes, 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

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

QUESTION 11: Is the individual 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.

Question 12: Calculates the consumer's Nutritional Risk Score based upon the responses to 2.A. 1-11.

The Nutritional Risk Score will automatically populate if all questions are answered.

3. USE OF MEDICAL SERVICES

3.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 3.A.3. If Yes, Complete 3.A.2. If Unable to Determine, Document Details in Notes section.

NOTE: Stayed means 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.

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 in 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 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.

3.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 4.A.1. If Yes, Complete 3.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.

4. DIAGNOSES

The purpose of this section is to gather information and document:

- Individual's diagnoses or conditions specified in each question.
- The signs and symptoms specific to each medical diagnosis or condition.

Utilize the resource guide located on the last page of this document for unfamiliar medical terminology.

4.A. HEART/ CIRCULATORY SYSTEMS

Question 1: Select all HEART/CIRCULATORY systems 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 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.

4.B. GASTROINTESTINAL

Question 1: Select all GASTROINTESTINAL 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 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.

4.C. SKIN

Question 1: Select all SKIN 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: Check ALL affected SKIN location(s):

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

Question 3: 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.

4.D. ENDOCRINE/METABOLIC SYSTEMS

Question 1: Select all ENDOCRINE/ METABOLIC systems diagnoses:

Select appropriate response(s) for all diagnoses. If None, Skip to 4.E.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.

4.E. NEUROLOGICAL

Question 1: If there are NEUROLOGICAL diagnoses, select all types:

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

4.F. CANCER

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

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

Question 2: Select all current CANCER diagnoses:

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

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

Question 1: Select all ENT 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 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 or "Other" is selected, Document Details in Notes section.

4.H. 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: 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.

5. OTHER MEDICAL INFORMATION

5.A. 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? Document details for the weight changes in 5.B.3.

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.

5.b. HEIGHT/WEIGHT

It is important 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 5.A.5):

Select the correct response. If not listed, select "Other" and Document Details in 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

5.C. 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 or designee 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 or designees 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 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 6.A.1.

Question 3: Reasons for falls – Document Details in Notes

Select appropriate response. Document Details in Notes section.

6. ACTIVITIES OF DAILY LIVING (ADLs)

The Care Manager or designee will assess the individual's ability to perform their ADLs and the ability to manage them with reasonable safety.

ADLs include:

- Bathing
- Dressing
- Grooming
- Eating
- Transferring
- Toileting
- Bladder/Bowel Incontinence

- Walking

Responses to these questions capture the level of assistance required to perform ADLs. Choose one of the following:

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 or designee 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 to wash themselves.

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

Document Details in Notes section when additional information is provided.

6.A. ADLs

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

Select appropriate response.

Question 2: 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.

Question 3: 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.

Question 4: EATING: Ability to eat/drink; cut, chew, swallow food; and to use any needed assistive devices:

Select appropriate response.

Question 5: 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.

Question 6: TOILETING: Ability to manage bowel and bladder elimination:

Select appropriate response.

Question 7: BLADDER CONTINENCE: Indicate the description that best describes the individual's BLADDER function:

Select appropriate response.

Question 8: WALKING: Ability to safely walk to/ from one area to another; manage/ use any needed ambulation devices:

Select appropriate response.

7. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)

7.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 identify physical and cognitive limitations.

When administering the IADL questions, it is very important 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.

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

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

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.

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.

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.
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.

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.

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.

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.

Question 9: MANAGING MEDICATIONS: What is the individual's ability level to manage medication?

Select one response.

8. INFORMAL SUPPORTS

8.A. INFORMAL HELPER(S) INFORMATION

Completion of this section may determine the presence of a primary caregiver and lead to the completion of the Caregiver Assessment Tool (CAT) to assess the caregiver's needs for 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 8.B.1. If Yes, Complete Section 8.A & B.

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.

8.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?

Document the information for the assistance needed.

9. PHYSICAL ENVIRONMENT

9.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: 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 3: 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.

10. EMERGENCY INFORMATION

10.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.

11. EMERGENCY PLANNING

11.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 individual oxygen dependent?

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

An individual is considered oxygen dependent if 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.

12. REFERRAL FOR NAT OR LEVEL OF CARE DETERMINATION

12A. REFERRAL FOR NAT OR LEVEL OF CARE DETERMINATION

Question 1: Case Aide believes the individual should be referred for a NAT or level of care determination:

Select No or Yes.

Question 2: Signature of Case Aid/ Staff:

Enter the appropriate name.

Question 3: Date of Case Aid/ Staff's Signature:

Enter the date of signature.

Question 4: Care Manager believes the individual should be referred for a NAT or level of care determination:

Select No or Yes.

Question 5: Signature of Care Manager:

Enter the appropriate name.

Question 6: Date of Care Manager's Signature:

Enter the date of signature.

Question 7: Supervisor believes the individual should be referred for a NAT or level of care determination:

Select No or Yes.

Question 8: Signature of Supervisor:

Enter the appropriate name.

Question 9: Date of Supervisor's Signature:

Enter the date of signature.

RESOURCES

4.A. 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.C. 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.

5.A. 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.