2017 Consumer In-Home Services Assessment Form

Updated February 10, 2017

Basic Client Information:			**Date of Assessment: / /**
*First Name:		*Last Name:	Middle Initial:
*Date of Birth: / /	*Age:	*Gender: ☐Male ☐Female ☐Other	Are you a veteran? ☐Yes ☐No
What is your primary language?		*What is your race?	*Are you Hispanic or Latino? ☐Yes ☐No
*Are you visually impaired (cannot be corrected with glasses)? ☐Yes ☐No			Are you receiving Medicaid? ☐Yes ☐No
Do you wear glasses/contacts? ☐Yes ☐No			Do you have hearing problems? ☐Yes ☐No
*Do you live alone? ☐Yes ☐No	Are you married? ☐Yes ☐No		How many people live in your household?

What is your monthly individual income?		What is your monthly household income?	
*What is your monthly income range?	☐ $1,005 or less ☐ $1,006 to $1,256 ☐ $1,257 to $1,859 ☐ $1,860 or more	*What is you and your spouse's combined monthly income range?	☐ $1,353 or less ☐ $1,354 to $1,691 ☐ $1,692 to $2,503 ☐ $2,504 or more

*Residential Street Address:		Mailing Address - Street/P.O. Box:	
*Apartment or Unit # (if applicable):		Mailing City or Town:	
*Residential City or Town:		Mailing State, Zip Code:	
*Residential State, Zip Code:		Email Address:	
*County of Residence:			
*Primary Phone # (including area code):		Secondary Phone # (including area code):	
Directions to the client's home:			

Emergency Contacts:	**First and Last Name**	**Phone Number**	**Relationship**
Primary Contact:			
Secondary Contact:			
Primary care physician:			
Caregiver (if applicable):			
POA (if applicable):			

Type of Power of Attorney:

How did you hear about our services?

☐AAA Brochure/Flyer ☐AAA Newsletter ☐Channel 9 Senior Source (TV) ☐Congregate Meal Site ☐From a Current Client ☐From a Friend/Relative ☐Senior Fair ☐Walk-In ☐Web Site ☐Other_____

Client's Mobility and Health Conditions:	**Client's Home Condition and Pets:**
Does the client use any mobility devices? ☐None ☐Ambulatory ☐Cane ☐Crutches ☐Electric Scooter ☐Walker ☐ Wheelchair ☐Other: _____ Is the client memory impaired? ☐Yes ☐No Has the client been diagnosed as being diabetic? ☐Yes ☐No Does the client use oxygen? ☐Yes ☐No Does the client use incontinence supplies? ☐Yes ☐No Does the client need supervision? ☐Yes ☐No Does the client have any of the following disabilities? ☐Autism ☐Epilepsy/Seizure disorder ☐Intellectual disability ☐Other: _____	Does the client smoke? ☐Yes ☐No Is the home in need of repair? ☐Yes ☐No If so, list what kind (especially if safety concern): _____ Are there any pets in the household? ☐Yes ☐No If so, what pets does the client have? _____ Any vicious pets (threat to in-home help)? ☐Yes ☐No Other helpful information regarding home condition or pets : _____ _____

Nutrition Checklist:	**Yes**	**No**	**Yes Score**
*I have an illness or condition that made me change the kind and/or amount of food I eat.			2
*I eat fewer than 2 meals per day.			3
*I eat few fruits or vegetables or milk products.			2
*I have 3 or more drinks of beer, liquor, or wine almost every day.			2
*I have tooth or mouth problems that make it hard for me to eat.			2
*I don't always have enough money to buy the food I need.			4
*I eat alone most of the time.			1
*I take 3 or more different prescribed or over the counter drugs a day.			1
*Without wanting to, I have lost or gained 10 pounds in the last 6 months.			2
*I am not always physically able to shop, cook and/or feed myself.			2
What is the consumer's nutritional risk score? **Total 'Yes' Score: _____** (0-2 = No Risk 3-5 = Moderate Risk 6 or more = High Risk)			
Are you interested in receiving nutrition counseling? ☐ Yes ☐No			

ADLs and IADLs required to determine eligibility for in-home services:					
ADLs (Activities of Daily Living)	**Yes**	**No**	**IADLs (Instrumental Activities of Daily Living)**	**Yes**	**No**
*I can eat without help.			*I can manage money without help.		
*I can dress myself without help.			*I can take care of shopping without help.		
*I can bathe myself without help.			*I can take my medication without help.		
*I can use the toilet without help.			*I can prepare meals without help.		
*I can get in and out of bed/chairs without help.			*I can do ordinary housework without help.		
*I can get around inside my home without help.			*I can use the telephone without help.		
			*I can use transportation without help.		
What is the consumer's ADL count? **Total 'No' Score: _____**			What is the consumer's IADL count? **Total 'No' Score: _____**		
Are you receiving assistance with ADLs or IADLs from anyone? ☐Yes ☐No			From whom are you receiving assistance with ADLs and or IADLs? _____		
Other Eligibility Criteria:				**Yes**	**No**
*Does the client require Home Health Aide based on orders from a physician?					
*Does the client reside in a rural area?					
*Is the client homebound or in a geographically isolated location to justify home delivered meals?					
*Can the client perform chore activities without help?					
*Comment on the client's inability to perform chore services:					
*Does the client have cognitive impairment? ☐None ☐Mild ☐Moderate ☐Severe (Requires assistance in routine situations due to lack of cognitive functioning)					

I have been informed of the policies regarding voluntary contributions, complaint procedures and appeal rights. I am aware that in order to receive requested services, it may be necessary to share information with other departments or service provider and I herewith give my consent to do so.
(If filled out by assessor or via phone, please have assessor check here and sign below ☐).

Signature_____ Date_____

Office use only: Information filled out by _____ Date_____

Please read the following information concerning this Intake Form and Complaint/Grievance Procedure:

We are asking you to complete the attached form to the best of your knowledge so we understand how you would like to receive services. Some basic information (*) is needed to meet compliance with federal and state reporting requirements and to target consumers age 60 and older who have the greatest economic and social need, such as individuals who are low-income minority, frail, and rural. Requests for services are processed as funds allow.

Your income level is not used to qualify you to receive services, but rather as a means to gather demographic data to various entities to show the need for continued funding of services. Nobody will contact you, unless you choose so in order to receive information about services which might be available to you.

If there is not enough room on the application for any of your responses, please attach a separate sheet.

Complaint/Grievance/Appeal Procedure:

The purpose of the Complaint/Grievance/Appeal Procedure is

- To ensure fair and equitable treatment of all consumers, eliminate dissatisfaction, resolve problems and
- To establish complaint and appeals procedures that inform the consumers of their rights to complain and receive a written response at the provider level

Any OAA/OCA (Older Americans Act/Older Coloradans Act) eligible consumer who has a complaint/grievance with the organization asking you to fill out this assessment form has the right to file a complaint/grievance with said organization and, if not satisfied with the organization's decision, to appeal that decision with either the local AAA (Area Agency on Aging) or the SUA (State Unit on Aging).

The complete Complaint/Grievance/Appeal Procedure is available upon request by contacting your local AAA and/or the SUA as follows:

Office of Community Access and Independence
Aging and Adult Services
1575 Sherman Street, 10th Floor
Denver, CO 80203
(303) 866-2800 (Main Line)
(303) 866- 2977 (Fax)
(888) 866-4243 (Toll Free)

Contributions:

Any person receiving services shall have the opportunity to contribute towards the cost of the service. No eligible person shall be denied a service because of their inability and/or choice not to contribute.

KEEP THIS FORM FOR YOUR RECORDS

Instructions about filling out the 2017 Consumer In-Home Services Assessment Form:

This Consumer In-Home Services Assessment From needs to be filled out by the AAAs or their providers to gather the information required by the federal or state government to be entered into Colorado's official data system (currently SAMS). In addition to register a client in SAMS, by entering date into the detailed consumer record, the rest of the required information needs to be entered into the assessment portion of SAMS.

(*) Any fields with this prefix designate demographic data collected by the federal or state government to support the need for continued funding for the various programs. This data will be de-identified and used in aggregate form to compile statistical information. None of the data is sold to a third party and any personal information will only be used in an effort to better serve the client in providing him/her with services.

There are some required fields you need to be aware of when entering the assessment into SAMS:

- 'Is the client's income level below the national poverty level?', which shows up on the consumer record in the NAPIS section as 'In poverty?'. Please check Yes, if the consumer has less than $1,005 individual or less than $1,353 household income monthly; mark 'no' otherwise.
- 'Is the client frail', which is in the Other Eligibility Criteria section of the assessment. Please check 'Yes' if the client has more than two ADLs or needs supervision due to cognitive impairment.
- A client has to be homebound to qualify for home delivered meals. You find an explanation of what qualifies when entering the assessment into SAMS.
- When you enter the 'What is your race?' question of the assessment into SAMS, the only thing that comes across to the consumer record is a 'Yes' or 'No' on the 'Is Ethnic Race specified?' question under the NAPIS section of the consumer record. You still need to mark the correct race under the Ethnic Races section on the right side of the consumer detail record screen; it does not cross-populate.

Any fields which do not have the (*) prefix are optional ,but help determine in what other ways we might be able to help the client and to get feed-back about which of our outreach programs are successful. Please try to obtain as much information as possible, since we can only help when we know that there is a need.

While we ask you to make an honest effort to gather this basic information, we cannot deny services to clients on the basis of them refusing to provide the requested information, since our programs are not means tested. Since our programs are specifically for the elderly, particularly for persons age 60 or over, the date of birth needs to be filled in. If the client refuses to provide his/her date of birth, please enter January 1 and the year which would make them the age they are stating. Then, indicate in the notes of the consumer detail record that the date of birth is not factual, as the client would not provide it.

This form must be used for clients receiving one or more of those services and clients have to be reassessed every six months (except for counseling and screening, where the client needs to be assessed only once):

- Adult Day Care/Adult Day Health or Adult Day Care/Adult Day Health (State)
- Case Management or Case Management (State)
- Chore or Chore (State)
- Home Delivered Meals or Home Delivered Meals (State)
- Home Health Aide or Home Health Aide (State)
- Homemaker or Homemaker (State)
- Personal Care or Personal Care (State)
- Screening or Screening (State) – no reassessment required

If you have any questions, please contact your local AAA office.