

**A**DVANCED  
**I**NFORMATION  
**M**ANAGER  
FOR  
**S**OUTH **C**AROLINA



MARCH 2013



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# Chapter II **SETTING UP AIM**

## **PART A System Requirements**

The State Unit on Aging (LGOA) and Saber Corporation **recommend** the following system requirements for **AIM** to operate at its best: For a complete checklist of **AIM** requirements, see **Appendix A**.

1. AIM Hosted requires that you run one of the following Operating Systems:
  - a. Windows XP
  - b. Windows Vista
  - c. Windows 7
  - d. Windows Server 2003
  - e. Windows Server 2008
  - f. Windows Server 2008 R2
2. All Operating Systems should have the latest service pack from Microsoft installed.
3. All Operating Systems should have Microsoft .NET Framework 3.5 with Microsoft .NET Framework 4.0 installed.

**NOTE: The setup above is only the minimum of what AIM requires to run on.**

4. Super VGA video card and monitor set at to at least 1024 x 768 pixels with 256 colors
5. Microsoft Remote Desktop (Standard with Windows XP computers or above.
6. High-speed broadband Internet connection
7. Bar Code Scanner recommended, but not necessary



## PART B PREPARATION

**NOTE:** These instructions are for Web-Hosted Remote Desktop AIM.

1. You must have already contacted Saber Corp. to obtain your “AIM” User ID(s) and Password. If you have not received an e-mail with this information, please contact Saber Corp. before proceeding (888-373-2090 or support@sabersite.com).

2. AIM Setup Information:

To create an icon on your desktop to launch the remote desktop please follow the instructions below.

- Right click on Start Menu. Click All Programs, Accessories. Right click on “Remote Desktop Connection”. Send to. Desktop (create shortcut).

Note: Please give Saber a call if you need any assistance.

3. Double click on Remote Desktop Icon.

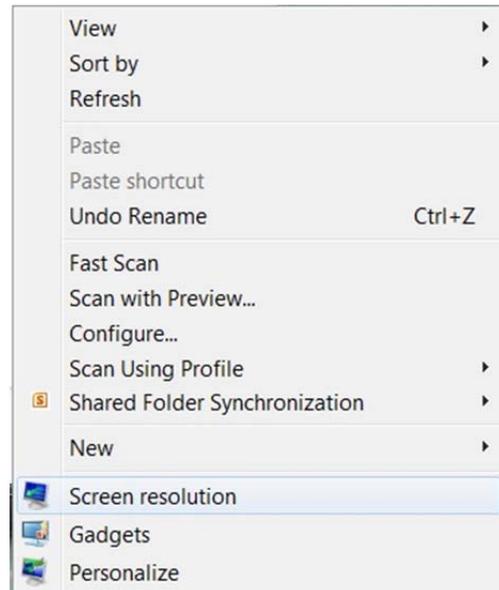


4. Click the options arrow:
5. From the e-mail you received from Saber Corp., type the telephone number after the “SABERSITE\SC
6. Your screen resolution and AIM Icon will need to be set to show 1024x768.

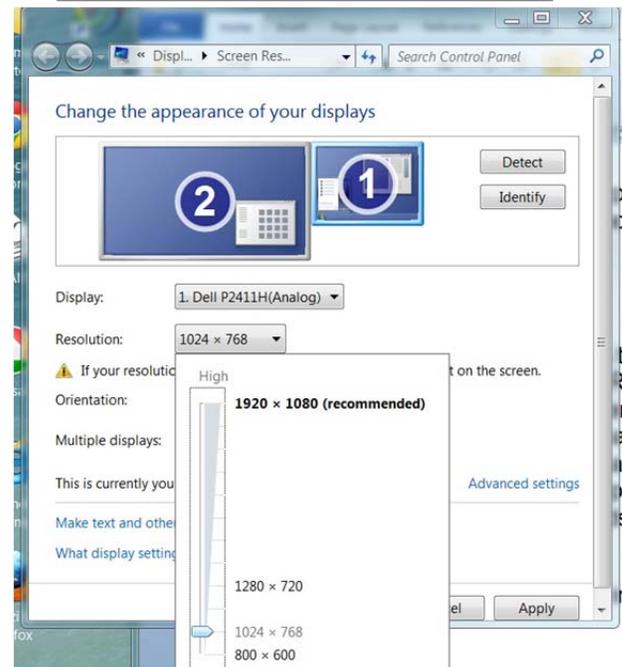


The screen resolution needs to be changed for the computer. The instructions below are for Windows 7 - the procedure is similar on Windows other Windows operating systems:

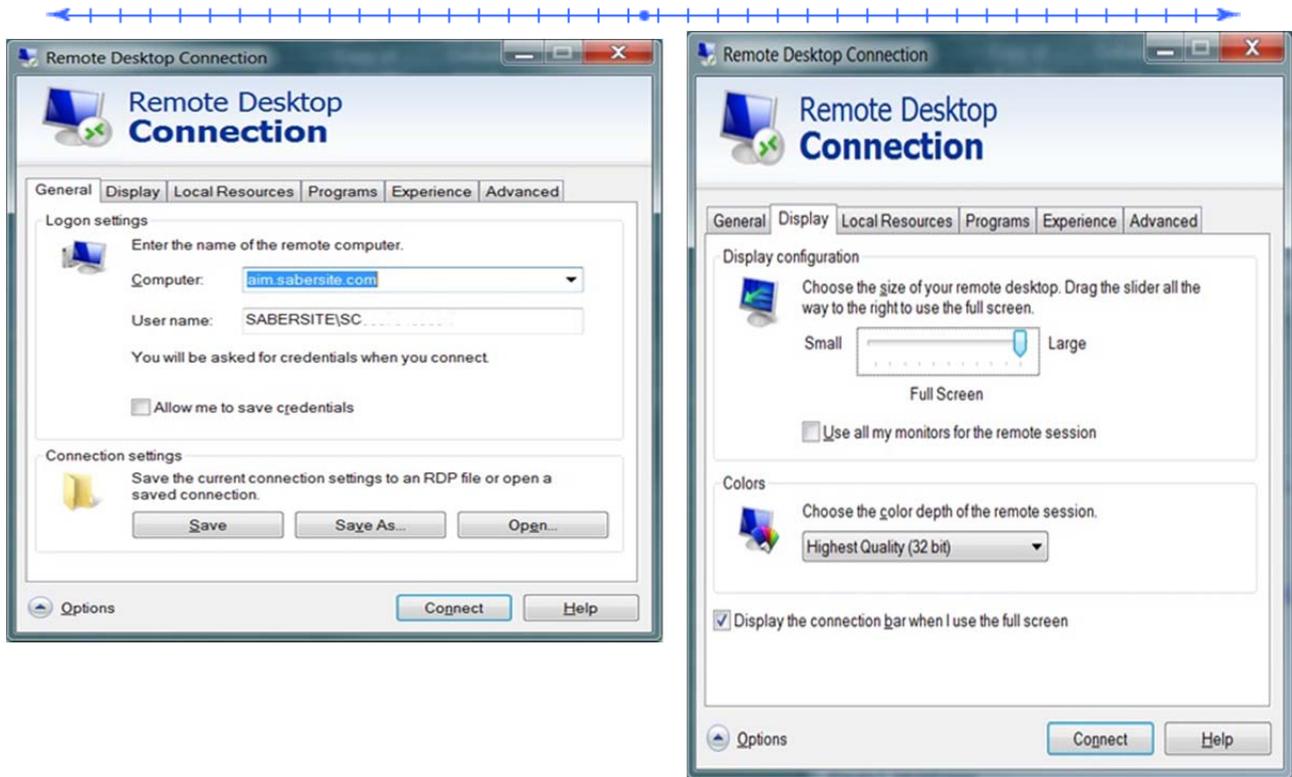
- a. Right click on an empty location on the desktop select Screen resolution from the popup menu.



- b. Click on the settings tab Change the Screen Resolution to 1024x768 or higher. Click OK If a pop up box appears asking you to accept the changes - accept them.
- c. Close all the open windows.



7. Your AIM Icon may also need to be changed.

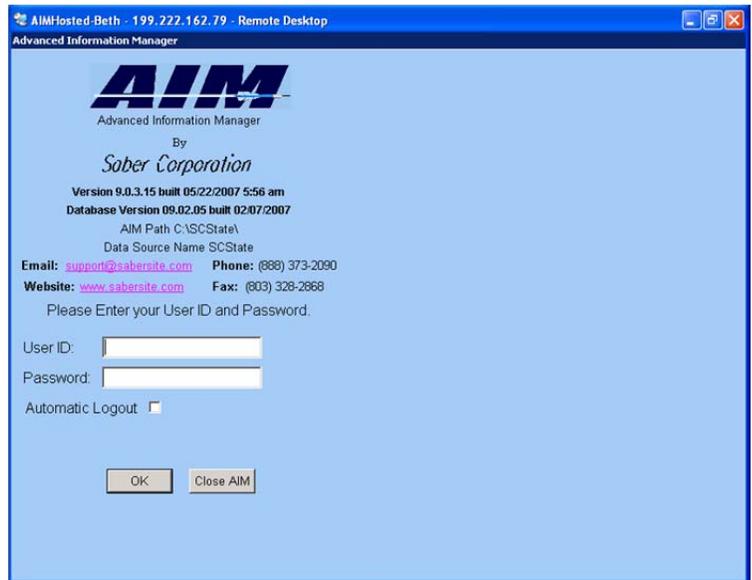


- Click the Display Tab
- Move the Display slider to 1024x768 OR Full Screen Click on the General Tab
- Click the Save button on the General tab to save the changes.
- Click Connect (You may CHECK THE BOX by Remember my credentials so that it doesn't keep displaying).





8. This should take you to the AIM Log-In Screen.
9. If you get a message about not being able to login, check your Username, password, and domain.
10. If you still cannot get to the AIM login screen, please contact Saber Corp. for further assistance.

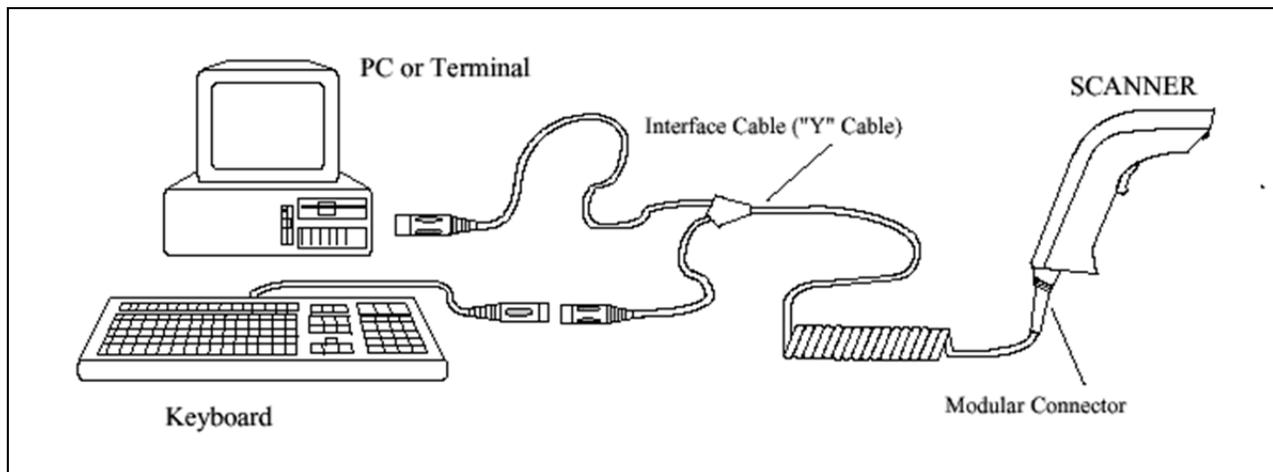




## PART C INSTALLING THE BAR CODE SCANNER

To install the keyboard-attached Bar Code Scanner:

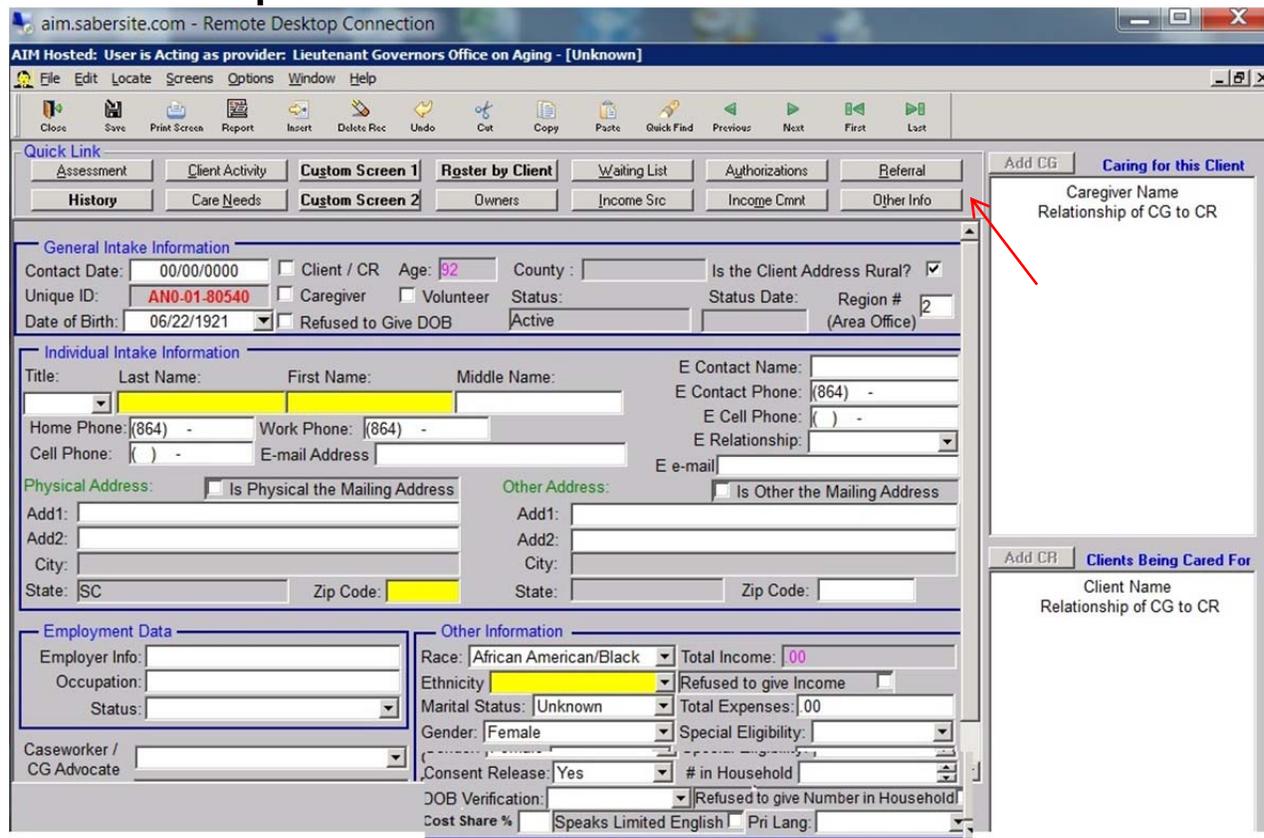
- **Shutdown** the computer.
- **Unplug** the **Keyboard** cable from the CPU.
- Use the “**Y**” connector that comes with your scanner to attach the scanner to the PC’s keyboard cable and CPU.
- When the computer is **restarted**, the scanning wand will be active.



- Or better yet, get a USB Barcode Scanning Wand.

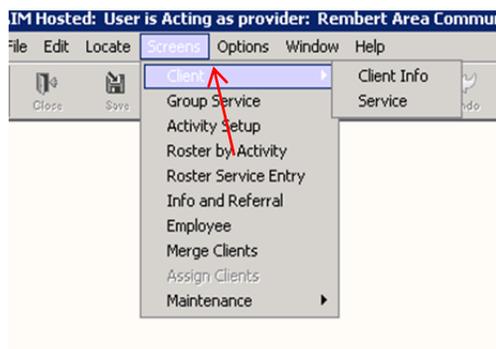


# Chapter III CLIENT INFORMATION



The **Client Info** screen provides **Quick Links** to other screens, such as the **Assessment**, **Roster**, and **Waiting List** screens. It also displays services received by the client.

## PART A Entering Data for a NEW Client



1. **Click** on the **Screens** menu item, then **Client**, then **Client Info**.
2. This will bring you to the **Client Quick Find** screen.

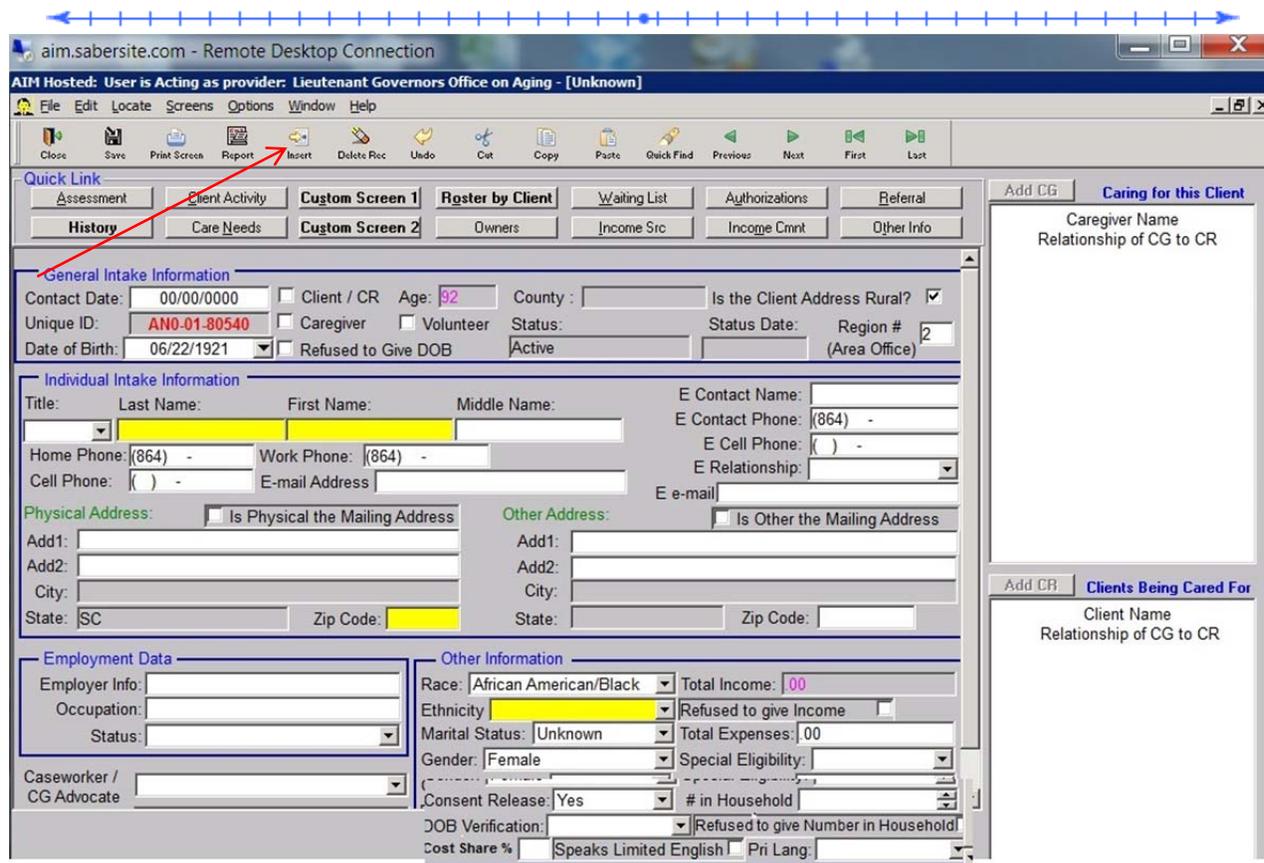
3. **Double Click** on any name to bring up the **Client Screen**.

4. In **AIM**, you must first pull up an existing client before you can add another client into the system.

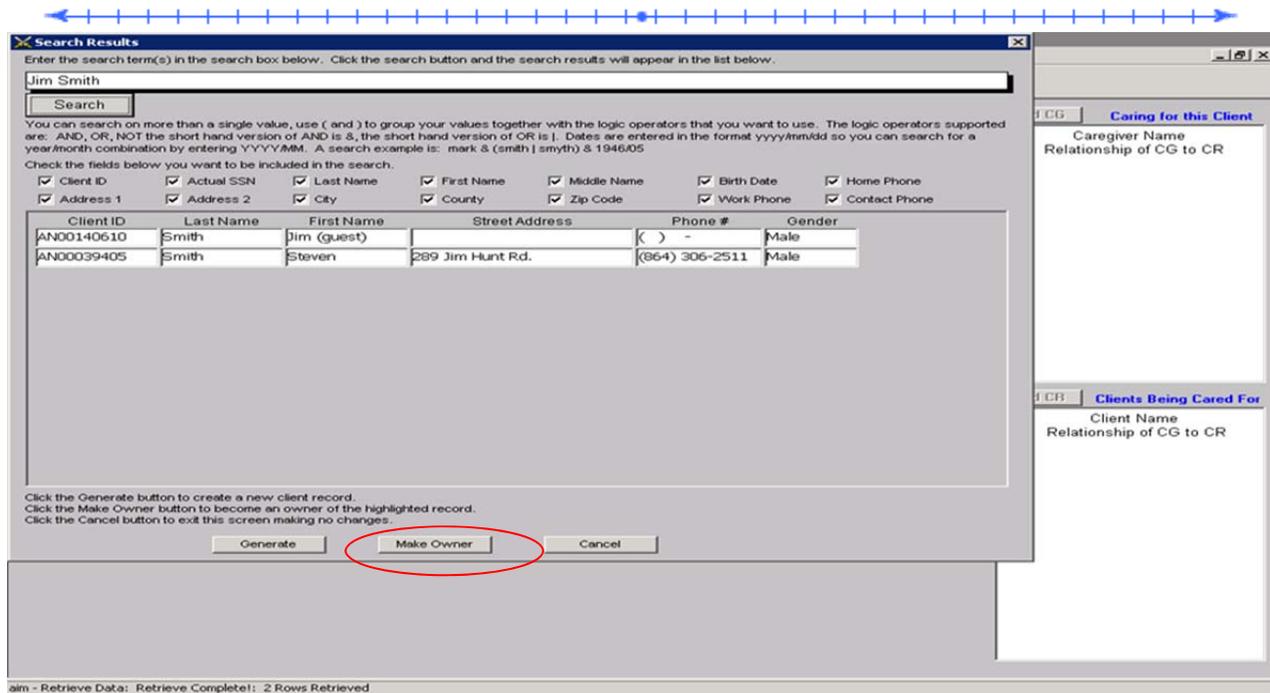
The screenshot shows the 'Client Quick Find' window with a table of clients. The table has columns for Client ID, Last Name, First Name, Middle Name, and Status. The client 'ABRACADABRA ABBIE' is highlighted in blue. Below the table is a search area with a 'Find:' text box, 'OK' and 'Cancel' buttons, and a 'Type of Search' section with radio buttons for 'Client Name (Last, First)' (selected) and 'Client SSN'. There is also a 'Show Active Clients Only' checkbox which is checked.

Client ID	Last Name	First Name	Middle Name	Status
000-21-00334				Active
000-21-00335				Active
000-21-00337	ABRACADABRA	ABBIE		Active
000-99-00484	ABRACADABRA	ABBY		Active
000-99-00325	ABRACADABRA	ABNER		Active
000-99-00488	ACROPOLIS	NANNIE		Active
000-99-00037	AERPLAIN	JEFFERSON		Active
000-00-00009	ALABAMA	ANNIE		Active
000-99-00458	ALASKA	EANIE		Active
000-99-00251	ALBERTA	DAISY		Active
000-99-00128	AMAZON	ZENA		Active
000-99-00463	AMERICA	JUJU		Active

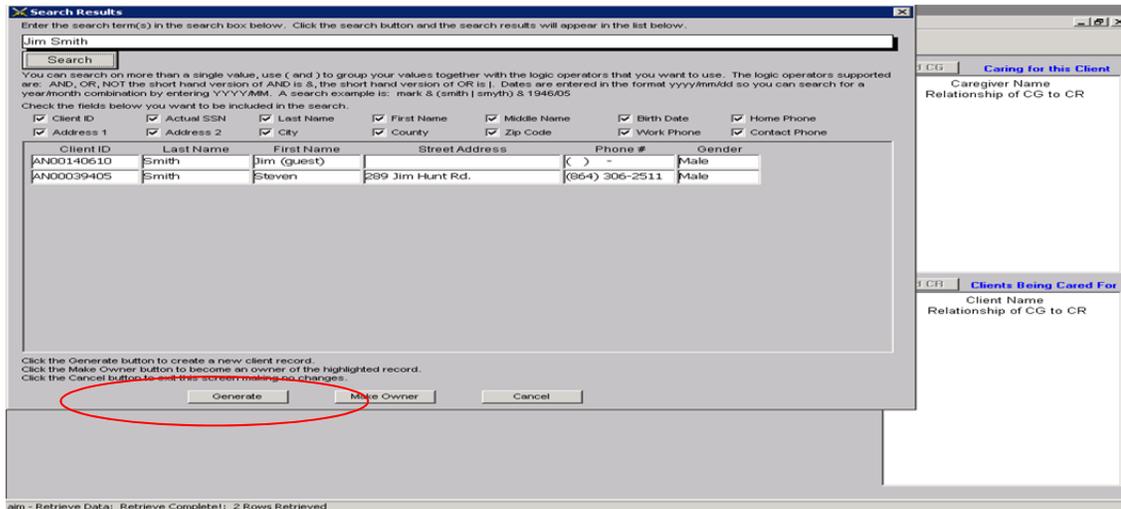
**NOTE:** You are forced to select a client before you enter a new client so that (hopefully!) you will be encouraged to look over the existing clients, to make sure that the “new” client you are entering is not already in the system. The LGOA recommends that you make it a standard procedure to always check existing clients, before inserting new clients to avoid duplication.



5. Once you have any client's record on the screen, you can **click** the **Insert icon** from the top menu (fifth icon from the left) to add a new client.
6. The **Client Search Screen** will be displayed. Type in a first and last name at a minimum. It is best to have all of the fields checked to widen a search. Notice "Jim" is listed in a street address.
7. If the correct client is listed, highlight the row and click **Make Owner**. (middle button at bottom of screen)



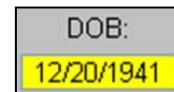
8. If the correct client is not listed, click the **Generate** button at bottom of screen.



9. A new **Client Screen** will be displayed.

10. Enter the remaining information into the **Client Screen**. Most of the boxes need no explanation; however, some of the boxes need further emphasis:

- a. **REQUIRED - DOB:** This is a critical field, used to place the client in an age range for reporting purposes. Date of Birth **MUST** be entered. If refused, attempt to obtain the year and enter as 07/01/YY. If





further refused, check Refused.

- b. **Status and Status Date:** these refer to the overall eligibility status of the client, and do not relate to any particular service or assessment. **Click** on the **Owners** button to see the choices for **Status**.

The screenshot shows the AIM software interface. At the top, there are several buttons: Assessment, Client Activity, Custom Screen 1, Roster by Client, History, Care Needs, Custom Screen 2, and Owners. A red arrow points to the 'Owners' button. Below this is a 'General Intake Information' form with fields for Contact Date, Date of Birth, Age, County, Rural Area, Unique ID, Actual SSN, Caregiver, Volunteer, Status, Status Date, and Region #. Below the form is a window titled 'The list below are the agencies that are tied to this client.' which contains a table with columns for Client Status, Provider Name, and Phone #. A red arrow points to the 'Active' dropdown menu in the table. At the bottom of the window are 'Close' and 'Save Close' buttons. Below the window is a table of service records.

Service Date	Units	Updated	Activity Name	Activity Group	Program	Funding	NAPIS Group
12/31/2002	2.00	01/08/2003	Richard Legal	Legal Assistant		Title III B	11 - Legal Ass
11/30/2002	.75	12/09/2002	Richard Legal	Legal Assistant		Title III B	11 - Legal Ass

The **Status** AND the **Status Date** are critical fields. They are used to pull clients for reporting. If the client’s status is Closed, Deceased, Inactive, or Pending, the client will not be included in some reports and rosters.

For a new client, the **Status Date** for **Active** will be the effective date that the client was approved for services and **must** be entered manually. (Status Date defaults to the date the record is being inserted and is not usually the date the client became active.)

**NOTE:** The **Status Date** DOES NOT automatically change when you change a clients status, you must change the date manually.

- When a client’s **Status** is **Closed**, **Status Date** is the date the client becomes ineligible for services (in other words, the date





the client is terminated).

- If a client is **Deceased**, **Status Date** should be the date of death or the date your agency learned of the client's death.
- If a client becomes ineligible for services, and there is reason to believe that this is only a temporary situation, the client's **Status** is **Inactive**, and the **Status Date** is the effective date of ineligibility for services.
- Information on a new client may be entered into **AIM** before the client is determined to be eligible for services. In that case, the client's **Status** is **Pending**, and the **Status Date** is the date that the preliminary information is entered into the system.
- If a client is entered onto a Waiting List, BUT NOT receiving any services, the client's **Status** is **Pending** and the **Status Date** is the date the client was put on the Waiting List.
- If a client is entered onto a Waiting List, BUT is currently receiving another service, the client's **Status** is **Active** and the **Status Date** would remain the date that the client became Active. (The Status Date would NOT change.)

- c. **Contact Information:** These fields relate to the client's address and phone numbers, as well as emergency contact information. **Check the Client Box** for Clients.
- d. **REQUIRED - County:**

**NOTE: County** can be automatically entered with a ZIP. The **County** correspond to the County in which the client resides, regardless of the county where the client is receiving services.

If ZIP code is not known, click within the ZIP code field, and a search screen will appear. First put in a state, then a city. Click on the top right button that says Search City & State. If a city shows 2 counties, pick the correct one. It is possible for a city to encompass multiple counties.

Click on the Return Selected button in lower left for the correct county.

The screenshot shows a search interface with the following elements:

- Zip Code:** An input field with a "Search Zip Code" button to its right.
- State:** A dropdown menu currently showing "South Carolina". A list of states is visible below it, including Alabama, Alaska, Arizona, and Arkansas.
- City:** An input field with a "Search City & State" button to its right.
- Table:** A table with four columns: State, County, City, and Zip Code. The table is currently empty.
- Buttons:** "Return Selected" (bottom left) and "Cancel" (bottom right).

- e. **Employment Data:** (Optional) If the client is employed, enter the employer's name and the employees's occupation.

f. **Click** on the drop-down arrow and select the appropriate Employment **Status** for the client.

g. **Other Information:**

- **REQUIRED - Race and Ethnicity:** Click on one selection from each list. If client refuses, check Refused box.

**AoA Race/Ethnicity Definitions:**

- African American, Not of Hispanic Origin -- A person having origins in any of the black racial groups of Africa.
- Hispanic Origin -- A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race.
- American Indian or Alaskan Native -- A person having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.
- Asian American/Pacific Islander -- A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands, Samoa and the Hawaiian Islands.
- Non-Minority -- Any person who is not considered a minority.

Source:  
[http://www.aoa.gov/prof/agingnet/NAPIS/SPR/SPR\\_guidance/definspr.asp](http://www.aoa.gov/prof/agingnet/NAPIS/SPR/SPR_guidance/definspr.asp)



- **Marital Status:** Click on selection from list.

- **Contact Date:** This is the date of the agency's first contact with the client. **This date should never change.**

Other Information

Race: 2 or more Races

Ethnicity: Hispanic

Marital Status: Married

Consent Release: Yes

Contact Date: 10/22/1992

Marital Status dropdown list: Divorced, Married, Separated, Single, Unknown, Widowed

- **Consent Release:** This should default to “No” based on information in the Employee Defaults screen. If, at this time, you have a signed release from the client, click on the down-arrow and **click** on “Yes”.

- **REQUIRED - Total Income:** This is a display from another data-entry window; you cannot type in this box. (See **Part B Quick Links** below.)

Total Income: 635.00

Total Expenses: 700.00

Special Eligibility: Spouse of Client

DOB Verification: Driver's License

# in Household: 2

- **Total Expenses:** (Optional) Enter the client's total MONTHLY expenses.

- **Special Eligibility:** IF client is under 60, but is eligible for Title III Services, enter the type of Special Eligibility under which the client qualifies for services. **Click** the drop-down arrow to choose a selection from list.

Other Information

Race: African American

Ethnicity: Non-Hispanic

Marital Status: Widowed

Gender: Female

Consent Release: Yes

Cost Share %

Total Income: .00

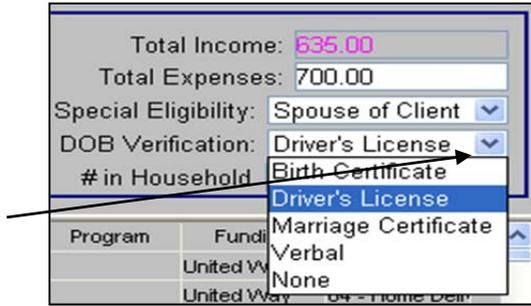
Total Expenses: .00

Special Eligibility dropdown list: Spouse of Client, Volunteer, Disabled Under E, Emergency, Other, None, Waiver, <=18 child, Neurological < 60

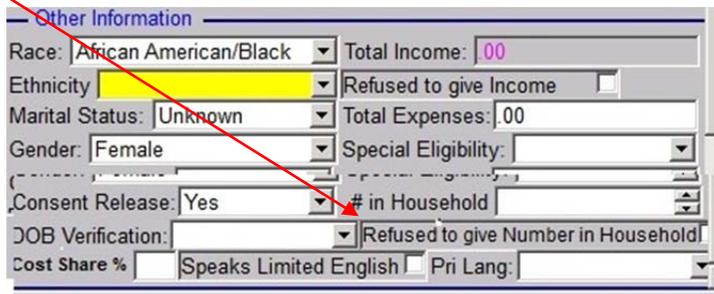
- **REQUIRED – Gender:** The client is either Male, Female or Refused.



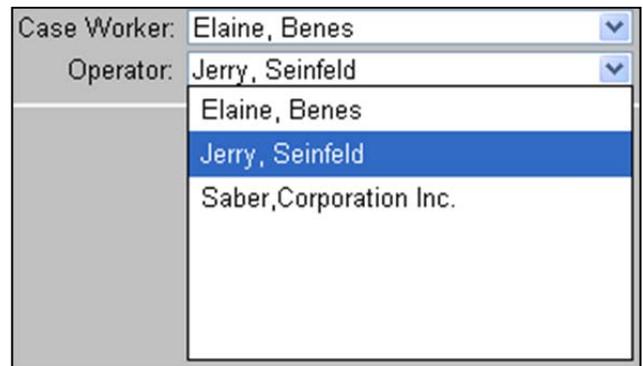
- **DOB Verification:** Enter the method used to determine that a client's age. **Click** the drop-down arrow to choose a selection from list.
- **REQUIRED - # In Household:** **Double-Click** inside the box and type in the number of people living in the client's home (or use the up and down arrows to reach the number).



Client, self = 1  
 Client + 1 other = 2  
 Client + 2 others = 3  
 Etc...



- h. **Case Worker/CG Advocate:** **Select** the Caseworker for this client from the drop-down list of employees.
- i. **Operator:** **Select YOUR** name (since you are entering the data into **AIM**) from the drop-down list of employees.
- j. **Save:**





k. Update Quick Find:



## PART B Quick Links from the Client Screen

The Quick Link Buttons can take you directly to other Data Entry Screens, related to the Client Screen currently open. Notice on different Client records that different button are in Normal Print, **Bold Print** or **Grayed-Out** (grayed-out).

If a button is...	It means that...
Grayed-Out (grayed-out)	The Button is not available.
Normal Print	The Button is available, but NO data currently exists for that Screen.
<b>Bold Print</b>	The Button is available, AND data currently exists for that Screen.

**Assessment**

The **Assessment** Button takes you to the client's **Primary Assessment** Screen.(See **Ch. V** (5) for how to enter a client's assessment.)

**Client Activity**

The **Client Activity** Button displays a screen showing the Service Units, for this client. You can view OR enter activity data for this.

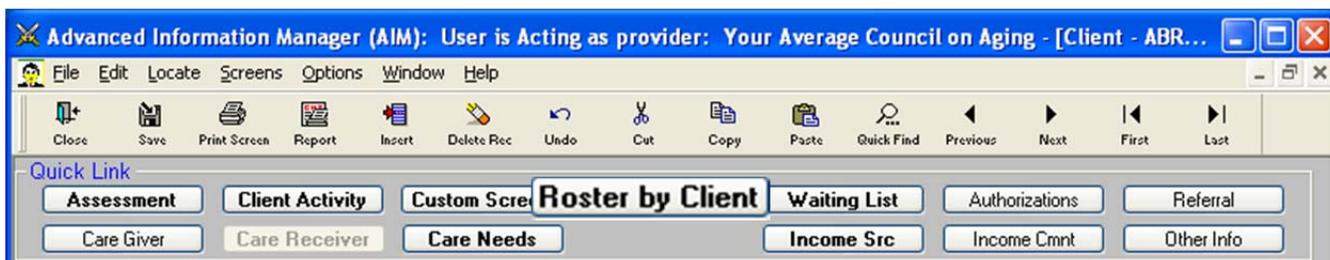
**Custom Screen**

The **Custom Screen** Button gives a screen to create client fields for information not found in the Client Screen.



**Roster by Client**

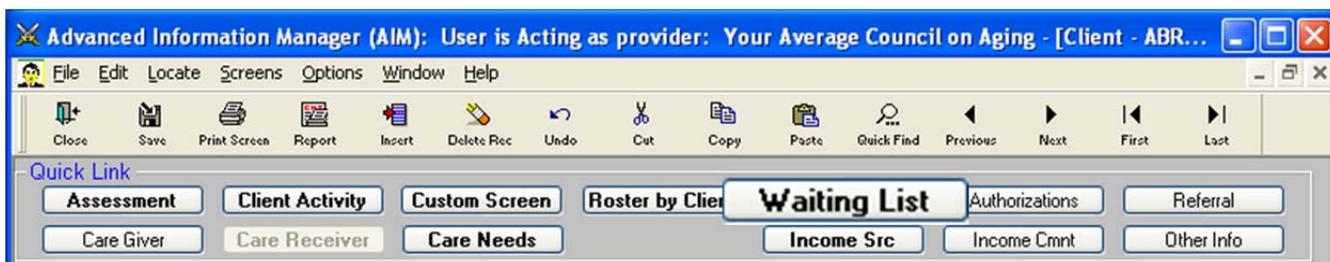
The **Roster by Client** Button pops up a window where



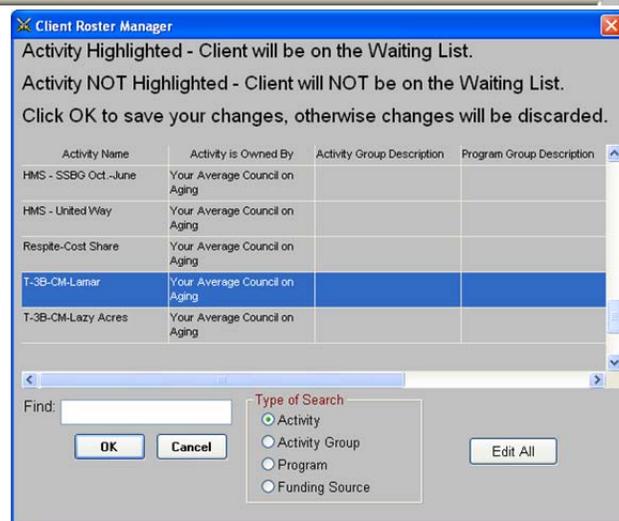
you can add this client to, or remove this client from, one or more rosters. Using this button, you can add or remove the client from the Roster(s) at the time that you initially enter the client or when you go into the client's record to change the status. (See **Chapter VI** (6) for instructions on using the Client Roster).

**Waiting List**

The **Roster by Client** Button pops up a window when



adding client to, or remove this client from, one or more Waiting Lists. You can add or remove this client from one or more Waiting Lists for services. (See **Chapter VII** (7) for instructions on using the Waiting List feature.)



The **Authorizations, Referral, Care Giver, and Care Receiver** Screens are used by Regional Family Caregiver Advocates. If agency is not part of Family Caregiver Advocate program, do not use these buttons.

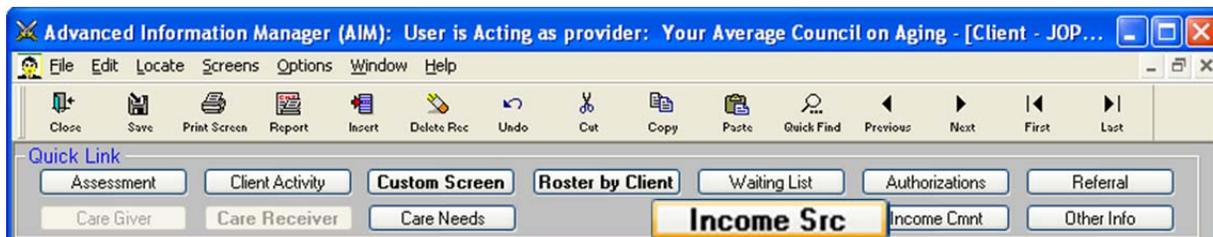
**Care Needs**

The **Care Needs** Button takes you to the **Care Needs** screen.

←-----→

This is where you may choose to enter case notes by date for this client.

**Income Src** The **Income Source** Button pops up a Window to enter MONTHLY income for this client.



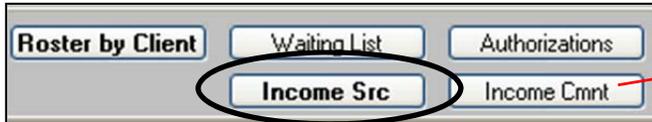
Use the following rules to determine what amount(s) to enter in this **REQUIRED** window:

- If the Client's Income is **KNOWN**:  
Enter the **TOTAL MONTHLY** income the client receives, either itemized by each of the sources listed or totaled in "**Other Income**", which ever works best for your agency. An "educated" estimated income is also acceptable. Then **Click OK**.
- If the Client's Income is **UNKNOWN** and an "educated" estimate is not feasible:

Then you should refer to the most current HHS Poverty Guidelines. You will ask the client for the "Household Size" (number in the household) and then ask if they are equal to or below the corresponding income figure. If YES, enter that dollar figure. If NO, and they are above that figure, enter \$9999 as their income. If they still refuse, check Refused.

**NOTE:** You **MUST** click on Income Source AND click OK, even if you do not plan to enter information: Income reports will not be correct, unless OK has been clicked from this window for EVERY client. It is a peculiarity of the **AIM** system.

**Helpful TIP:** You can tell whether or not the Income Source window has been “OK’d” by whether or not the **BUTTON** is in **Bold Print**: If “**Income Src**” is **Bold**, then it has been “OK’d”. If “Income Src” is NOT **Bold**, then it has NOT been “OK’d”.



The **Income Comnt** Button pops up a text window to type notes.



History: The **History** Button pops up a Window to show what client data fields contained before the last update.

Assessment	<b>Client Activity</b>	Custom Screen 1	<b>Roster by Client</b>
<b>History</b>	Care Needs	Custom Screen 2	Owners

<b>General Intake Information</b>			
Contact Date:	00/00/0000	Date of Birth:	02/26/1949
Unique ID:	<b>AN0-01-78786</b>	Age:	
Actual SSN:	260-00-0001	County:	YORK
	<input checked="" type="checkbox"/> Caregiver	Status:	Active
	<input type="checkbox"/> Volunteer	Status Date:	
	<input type="checkbox"/> Client / CR	Region # (Area Office):	3
		<input checked="" type="checkbox"/> Rural Area	

APM Hosted: User is Acting as provider: Catawba Area Agency on Aging Caregiver

File Edit Locate Screens Options Window Help

Client - Test, Paula

Quick Link: Assessment, Client Activity, Custom Screen 1, Register by Client, Waiting List, Authorizations, Referral, History, Case Needs, Custom Screen 2, Owners, Income Sec, Income Cont, Other Info

**General Intake Information**

Contact Date: 00000000 Date of Birth: 09/04/1950 Age: 52 County: York Rural Area  
 Unique ID: AMO 01 38808 Caregiver Volunteer Status: Status Date: Region #  
 Actual SSN: 260-00-0000 Client / CR Active (Area Office)

**Individual Intake Information**

Title: Last Name: First Name: Middle Name: E Contact Name:  
 Test Paula E Contact Phone: ( ) -  
 Home Phone: ( ) - Work Phone: ( ) - E Cell Phone: ( ) -  
 Cell Phone: ( ) - E-mail Address: E e-mail:

**Physical Address:**  Is Physical the Mailing Address  Is Other the Mailing Address

Address1: Dfjlsdf Address2: Sdfasdfa City: Rock Hill State: SC Zip Code: 29730

**Employment Data**

Employer Info: Occupation: Status: Retired CG Advocate:  
 Other Information: Race: African American Ethnicity: Non-Hispanic Marital Status: Widowed Gender: Female Consent Release: Yes # in Household: 1

**History - List of Revisions by date**

Modified Date	Action Taken	Provider (Acting As)	Modified By User
2/27/2012 09:06:09	updated	Catawba Area Agenc	SCREGION
2/27/2012 09:06:08	updated	Catawba Area Agenc	SCREGION
2/27/2012 09:05:40	updated	Catawba Area Agenc	SCREGION
2/27/2012 09:05:39	updated	Catawba Area Agenc	SCREGION
2/27/2012 09:04:21	updated	Catawba Area Agenc	SCREGION
2/27/2012 09:04:19	updated	Catawba Area Agenc	SCREGION
2/27/2012 09:04:00	updated	Catawba Area Agenc	SCREGION
2/27/2012 09:03:52	updated	Catawba Area Agenc	SCREGION
2/27/2012 09:03:49	updated	Catawba Area Agenc	SCREGION
2/27/2012 09:03:43	updated	Catawba Area Agenc	SCREGION
2/27/2012 09:03:19	updated	Catawba Area Agenc	SCREGION
2/27/2012 09:03:10	updated	Catawba Area Agenc	SCREGION
2/27/2012 09:02:56	updated	Catawba Area Agenc	SCREGION
2/24/2011 11:45:00	updated	Lieutenant Governors	DBA

**Data before Current Revision**

SSN: AMO13880  
 Actual SSN: 26000000  
 Last Name: Test  
 First Name: Paula  
 Middle Name:  
 Address1: Dfjlsdf  
 Address2: Sdfasdfa  
 City: Rock Hill  
 State: SC  
 Zip Code: 29730  
 County: York  
 Dob: 9/4/1950  
 Sex: Female  
 Marital Status: Widowed  
 Race Code: African American  
 Hispanic: false  
 IsClient: true

For Technical Support Call (888) 373-2090

Link to Caregiver:

Waiting List Authorizations Referral  
Income Src Income Cmnt Other Info

Add CG Caring for this Client

Caregiver Name  
Relationship of CG to CR

Select people that are caring for Test, Paula.

Highlight people that are caring for Test, Paula. Click OK when finished to save your selection.

Client ID	Last Name	First Name	Middle Name	Status	Date of B
cg0-00-2892	Tabor	Julia		Active	10/30/1932
cg0-00-2491	Talley	Danny		Active	8/28/1955
cg0-00-2770	Tatman	Beth		Active	6/21/1949
AND-01-54006	Taylor	Debra		Active	4/29/1963
cg0-00-2726	Taylor	Jo		Active	12/1/1931
AND-01-53928	Templeton	Anna		Active	3/4/1937
cg0-00-2405	Terry	Perrie	Michelle	Active	7/19/1962
AND-01-78786	Test	Velma		Active	2/26/1949
AND-01-73588	Teuton	Dorothy		Active	2/1/1931

Find: Test, Velma

Type of Search  
 Client Name (Last, First)  
 Client SSN

OK Cancel

Add CR Clients Being Cared For

Client Name  
Relationship of CG to CR

Link to Care Receiver:

Register by Client Waiting List Authorizations Referral  
Owners Income Src Income Cmnt Other Info

Add CG Caring for this Client

Caregiver Name  
Relationship of CG to CR

Select Clients for that are being cared for by Test, Velma.

Highlight Clients for that are being cared for by Test, Velma. Click OK when finished to save your selection.

Client ID	Last Name	First Name	Middle Name	Status	Date of B
AND-01-38808	Test	Paula		Active	9/4/1950
cg0-01-2891	Testa	Michael		Active	11/1/1936
AND-01-73590	Teuton	Robert		Active	10/15/1930
AND-01-53714	Tevebaugh	Ruby		Active	10/22/1926
AND-01-60980	Thomas	Carol	L	Active	9/27/1932
AND-01-53454	Thomas	Doris		Active	3/7/1927
AND-01-54044	Thomas	Edna		Active	1/9/1936
cg0-01-2892	Thomas	Naquone		Active	1/8/1993
cg0-01-2894	Thomas	Raymond		Active	2/13/1926

Find: Test, Paula

Type of Search  
 Client Name (Last, First)  
 Client SSN

OK Cancel

Add CR Clients Being Cared For

Client Name  
Relationship of CG to CR



## Information Required for Federal NAPIS/SRT Report:

### Client Screen

Date of Birth  
Gender  
Zip Code  
Ethnicity  
Race  
# in Household  
Income

### Assessment Screen

ADL's  
IADL's

## Information Required for Caregiver Federal NAPIS/SRT Report:

### Client Screen

Date of Birth  
Gender  
Zip Code  
Ethnicity  
Race  
Special Eligibility (Care Receiver Client Screen)  
Income  
# in Household

### Care Receiver link to Caregiver

Relationship

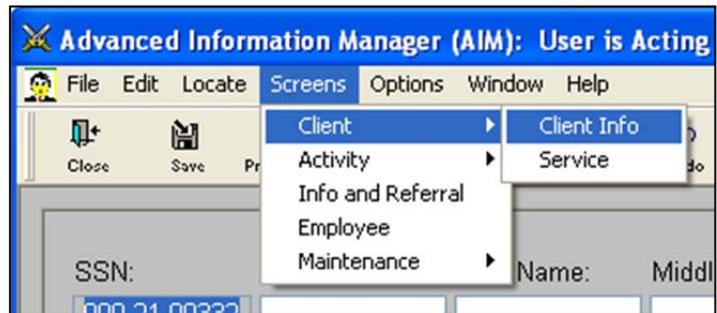
## CHAPTER IV ASSESSMENT DATA

After a client has been entered into **AIM**, the **Assessment Screen** is used to record client assessment and other information.

**NOTE:** This section is perhaps the most vital of the data collection process. Determining the accurate needs of the client, as well as the psycho-social condition of the client, which are often related to determining the accurate needs of the client will affect your agency's ability to best use funds.

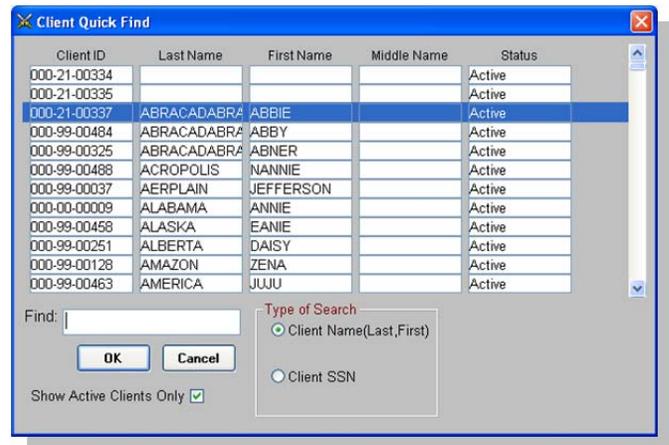
The priority risk score that is automatically generated by assessment answers is an effective way of ranking clients objectively according to greatest need for services.

1. **The Assessment Screen** is accessed through a client's record: From the Client Screen, **Click** on **Screens**, then **Client**, then **Client Info**.



This will bring you to the **Client Quick Find** screen.

2. **Click** on the client's name to highlight it, then **Click "OK."** The selected client's information screen will appear.



3. Click on the **Assessment** button from the **Quick Link** menu.



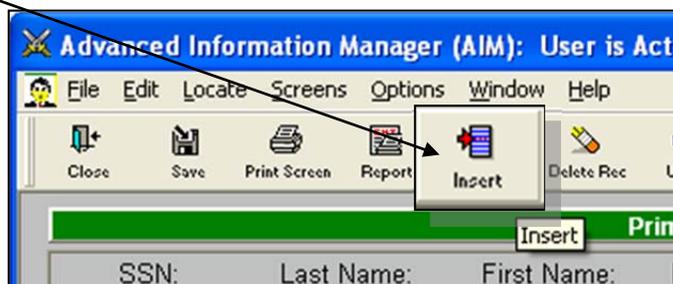
One of two events will occur next, based on whether the Assessment button is in **Bold Print** or in Normal Print:



- Normal Print: This is the **FIRST** assessment for this client and the **“No Records Found”** box will appear.
  - **Click OK** to insert the initial assessment.



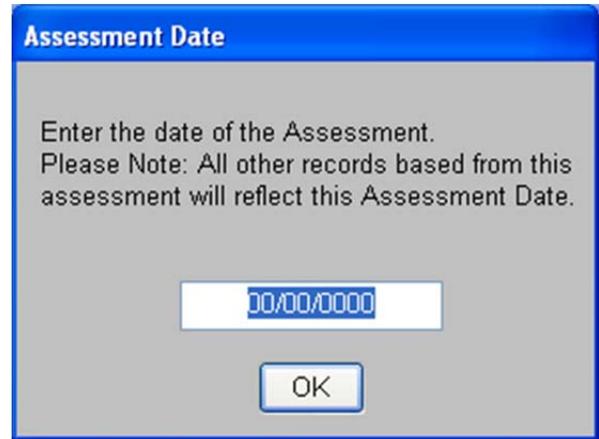
- **Bold Print**: This is **NOT** the first assessment for this client, so the client’s **MOST RECENT** assessment/re-assessment will display.
  - **Click Insert** to insert a re-assessment.



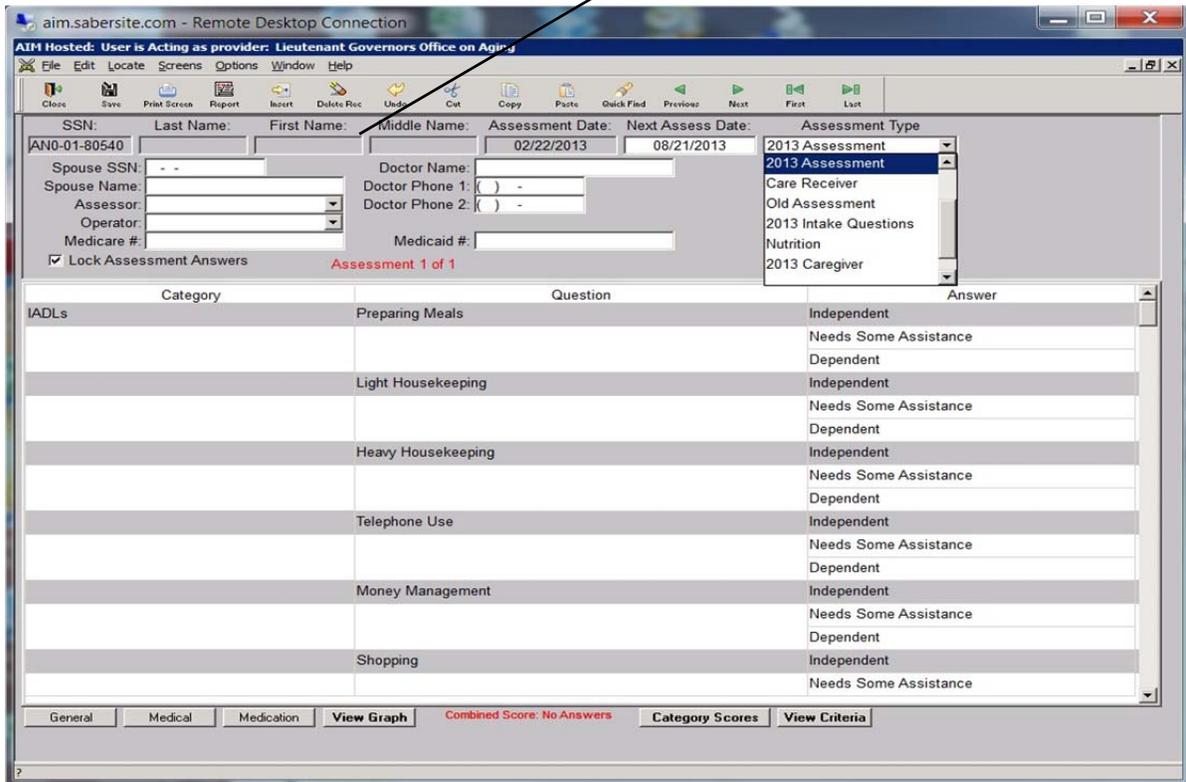
**NOTE:** Regardless of whether you Clicked “OK” to the “No Records Found” window, or whether you clicked “Insert,” once the client’s assessment window opened, you will proceed the same way for entering an Assessment or a Re-Assessment.

- A new window (**Assessment Date**) will pop-up asking for the assessment date.

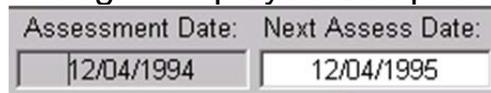
**Type** in the correct date and **click OK**.



The **Assessment Screen** will be displayed, with some information already filled in for the Top Half of the Assessment Screen with the heading **“Primary Assessment Information.”**



The “Next Assessment Date” is defaulted according to how many days between assessments your agency has set as default. If another date is desired, highlight and change the “Next Assessment Date” The AIM administrator can change the default for the next assessment date through “Employee Setup” screens.



## Entering a First Assessment or Re-Assessment

To ensure that those who need services receive them, there must be an in-depth screening process to evaluate an individual's needs. Only after this evaluation, can you recommend the most appropriate services.

### To Enter Data into the Top Half of the Assessment Screen (Primary Assessment Information):

**NOTE:** Only ONE section of the Assessment Screen is “active” at any time. To activate a section, click anywhere in the section below the section heading. The Heading Bar at the top of the section turns **green** to show that the section is “active.”

1. **SSN/UID, Last Name, First Name, and Middle Name:** The first four boxes of the screen are filled in from the client screen and unchangeable.
2. **Assessment Date:** The Actual Date the Assessment was performed. This is the date you typed into the **Assessment Date** window. **AIM will** allow you to select this field. **HOWEVER**, changing this date can cause unexpected results and loss of assessment data. If the date you entered was incorrect, **DELETE** the entire assessment and then re-insert it with the correct date.

Advanced Information Manager (AIM): User is Acting as provider: Your Average Council on Aging - [Ass

File Edit Locate Screens Options Window Help

**Primary Assessment Information**

SSN: 000-99-00484    Last Name: ABRACADABR    First Name: ABBY    Middle Name:    Assessment Date: 10/04/2003

Spouse SSN: - -    Doctor Name: DR.DOCTOR

Spouse Name:    Doctor Phone 1: ( ) -

Assessor: Suzie,Caseworker    Doctor Phone 2: ( ) -

Operator: Judge, Joe Brown

Medicare #: 0009900484    Medicaid #: 1234567890

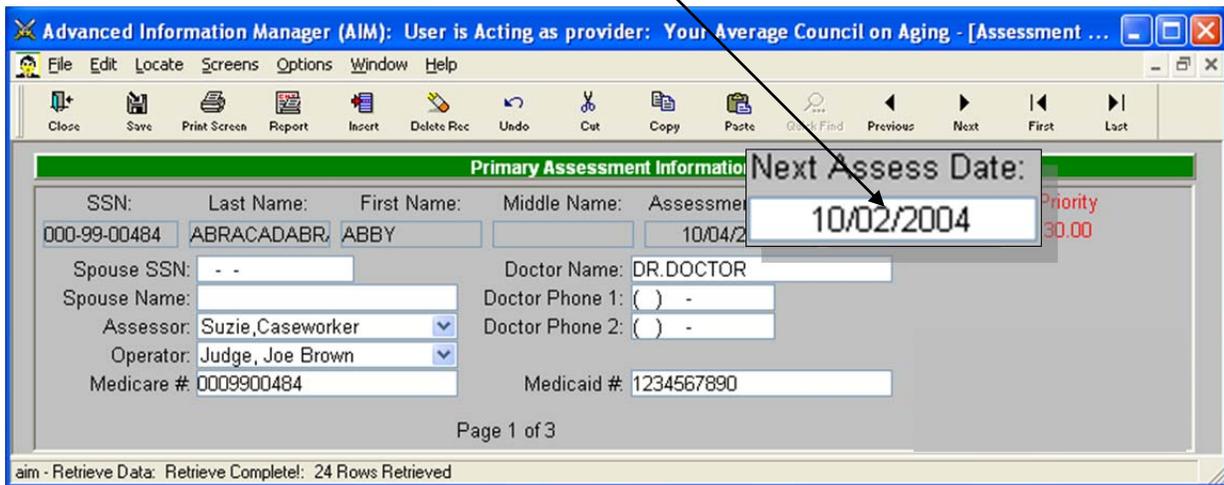
**To Delete an Assessment:** you must have the **Primary Assessment Information** section “active”: Click in the top half of the Assessment Screen to ensure that the Heading Bar is green.) Then **Click** the “Delete” button and **Click OK** to the warning message. You must be logged onto AIM as a User with Administrative authority to Delete an Assessment. Delete with caution!



**WARNING:** Once you delete an assessment, it is GONE, there is no “undo”.

**WARNING: DO NOT TYPE OVER THE ASSESSMENT DATE as a shortcut to entering a re-assessment for a client.** You MUST first INSERT a new assessment and then re-answer all questions for a re-assessment.

3. **Next Assess Date:** *AIM* will automatically insert a calculated date. *AIM* calculates this date by adding to the Assessment Date the number of days specified on the **Employee Defaults** screen. The default number of days can be changed from the Employee Defaults screen for each *AIM* USER. (Notify the appropriate Agency to change this default.) You may also change the Next Assess Date itself by typing over it.



**NOTE: Do Not** confuse Employee Default information set for *AIM* Users with the Assessor for this record. The Next Assessment Date will be calculated based on the *AIM* User logged into *AIM*, NOT on which employee is selected as the Assessor.

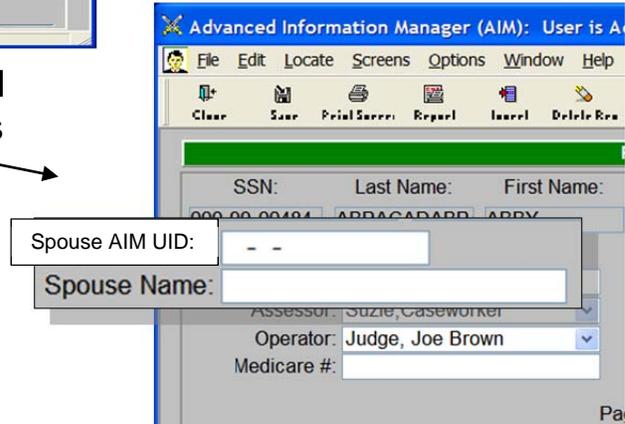
**Also NOTE:** The LGOA requires a minimum of **one assessment per year** (365 days) for clients receiving most core services, unless something has changed in the client’s condition or circumstances.



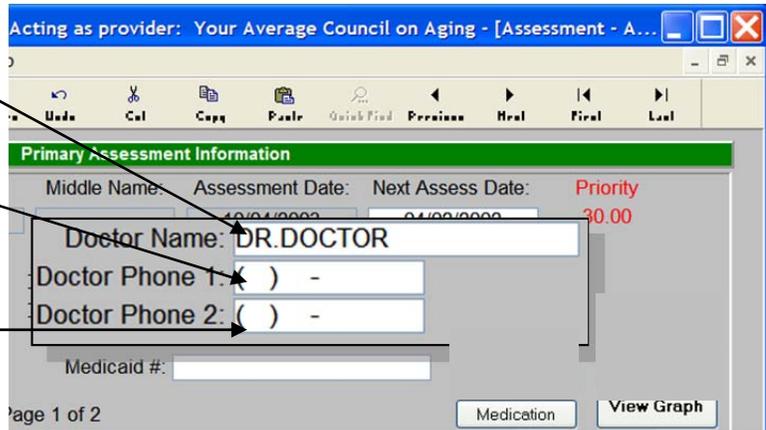
- Priority:** This is a pre-set calculated field. **AIM** will add the values of answers to designated assessment questions (The first 15 Categories) to determine the client's priority score.



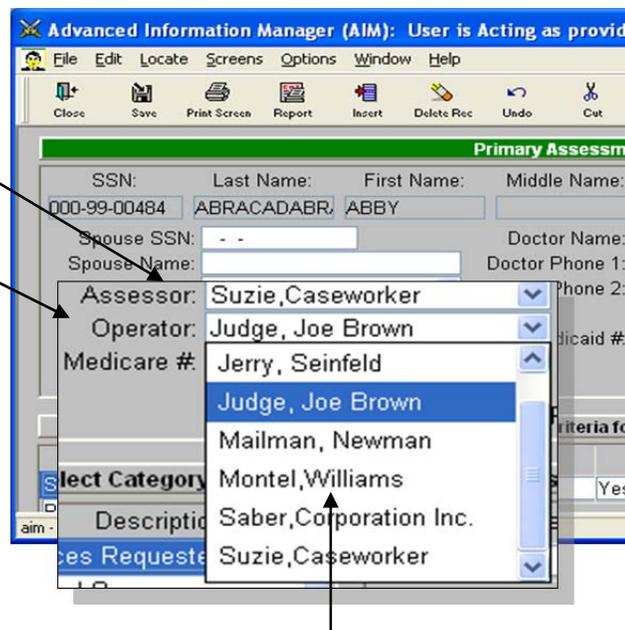
- Spouse AIM UID:** This is the AIM Unique ID assigned to the client's spouses record.
- Spouse Name:** Enter name of spouse, if applicable.



- Doctor Name:** Enter name of client's primary care physician.
- Doctor's Phone #1:** Enter the physician's phone number.
- Doctor's Phone #2:** Enter the physician's emergency number, if any.

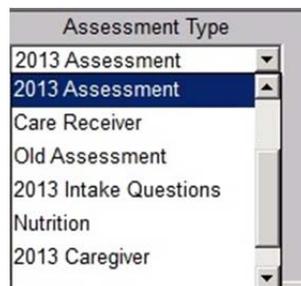


10. **Assessor:** **Click** on the drop-down box arrow and then on the name of the employee who performed the assessment.
11. **Operator:** **Click** on the drop-down box arrow and then on your name (as the **AIM** User performing the data entry task).



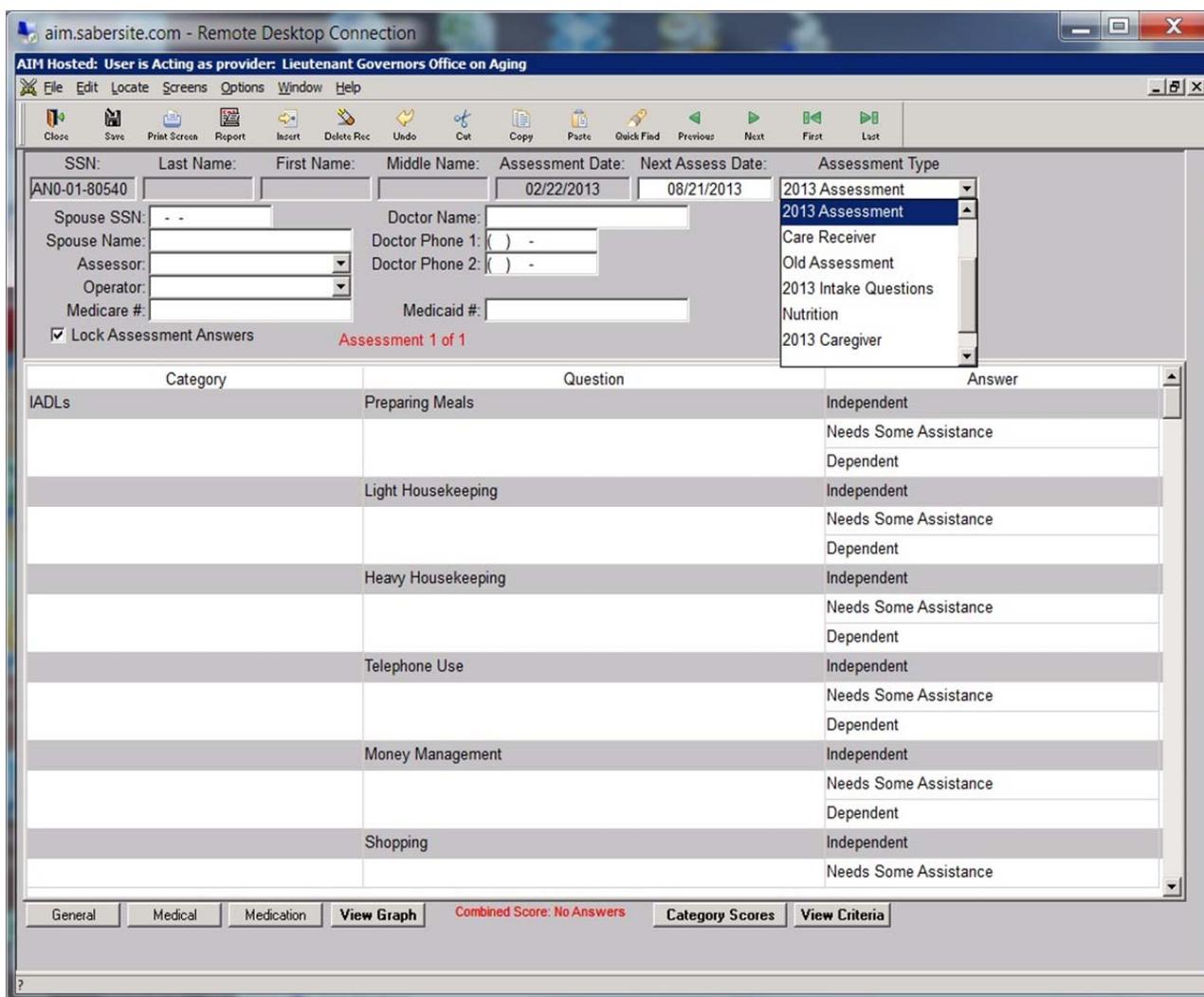
12. **Entering Assessment Criteria Information**

1. The NEW 2013 Intake Questions are:
  - Type of Transportation Needed In An Evacuation
  - Currently Receiving In-Home Services
  - Services Requested





2. The NEW 2013 Assessment Questions. These categories, questions, and answers are listed downwards on the screen. Categories may have several questions, but selected questions may have only one answer.
3. The “Assessment Answers” box must be unchecked before you can highlight and change information.
4. Selected categories and questions do not need to be answered, only answers.



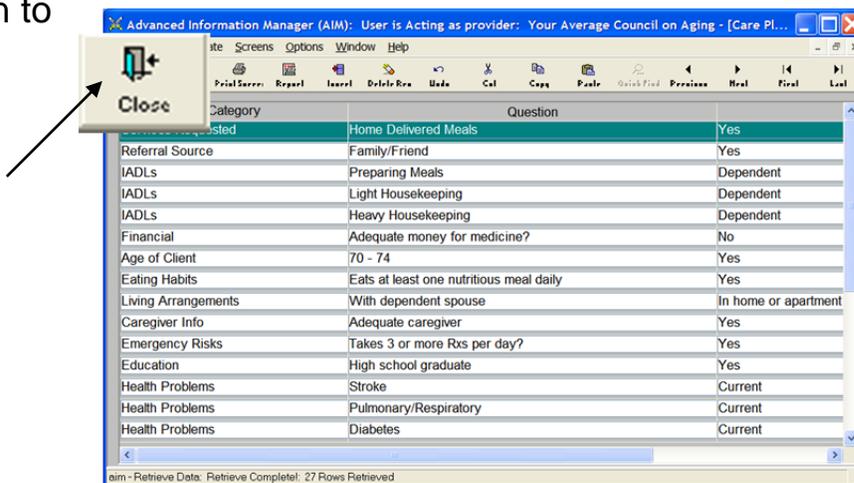


13. **Text Boxes:** Click  on any of these buttons to enter additional relevant **General, Medical** and/or **Medication** information about the client in three separate text boxes.



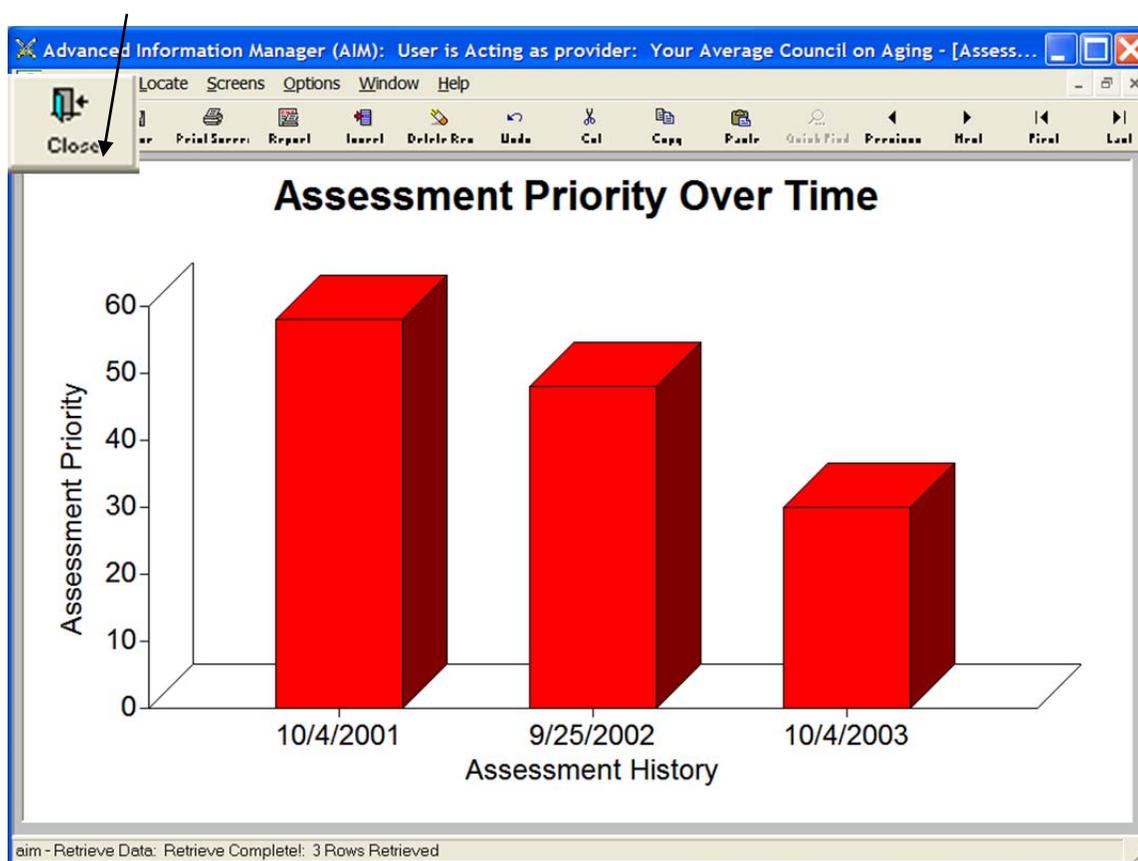
14. **View Criteria:** Once all data entry has been accomplished for this assessment, you may **click** on this button to view all categories of completed assessment data at one time.

15. **Click Close** to return to the Assessment Screen.



16. **View Graph:** As annual assessments are done for a client, **AIM** can produce a bar graph based on the priority scores it compiles. This visual representation is useful in monitoring the client's condition (improvement, maintenance, or decline) over time. This is why you should NEVER DELETE past assessment data.

17. **Click Close** to return to Assessment screen.





## Process to Answer Assessment Questions:

**NOTE:** Regardless of whether you are entering an assessment or re-assessment, you must **Click** on each Category and answer each question in that Category, according to the checklist on the previous page). **DO NOT** skip categories:

1. Repeat Steps 2 and 3 until all questions have been answered for that category.
2. Repeat Steps 1 – 5 until all categories have been completed.

**Following are detailed descriptions of some Assessment Categories, Question and Answer:**

### **CATEGORY: IADLs**

***You must answer ALL QUESTIONS in this category, regardless of the clients level of ability or inability to perform the tasks listed. Use the following definitions for each of the tasks:***

The IADL self-performance categories measure what the client actually did without assistance in the last 7-14 days, indicating balance between the client's self-performance and assistance caregivers provided for each activity. The assessor should use professional judgment to determine if the last 7-14 days are representative of the client's overall IADL ability.

- **Preparing Meals:** The ability to prepare a full, nutritious meal at least twice a day;
- **Light Housekeeping:** The ability to pick up small, light items, dust, sweep, wash own dishes or put dishes in dishwasher, do light laundry;
- **Heavy Housekeeping:** All of the above plus vacuum, heavy laundry, mop, clean bathroom(s);
- **Telephone Use:** Ability to look up numbers, dial phone, and carry on a conversation;
- **Money Management:** Ability to manage household finances properly;
- **Shopping:** Ability to purchase items, get them into the house, and put them away;
- **Managing Medications:** Ability to take medications timely and properly.

***Use the following definitions to accurately assess the client's level of ability:***

- **Independent:** Indicates the client is totally capable of completing the activity without assistance. The client can also be coded as "Independent" if the client received minor assistance or supervision only

one or two times over the past 7 days due to special circumstances, but completed the activity independently all other times for that week.

**Example:** Mr. U goes out one day a week to visit with family and returns in a fatigued state. He then requires help undressing for bed. He required no help dressing that morning, or any other day that week.

Thus, over the 7-day assessment period, Mr. U was fully self-sufficient 13 times and required hands-on help one time. Based on careful review, the client may be coded “Independent” in dressing.

- **Needs Some Assistance:** Indicates the client is capable of completing the activity with the assistance of a walker, wheelchair, cane, crutches, rails, or another type of assistive device. The client can also be coded as “Independent” if the client received minor assistance or supervision only one or two times over the past 7 days due to special circumstances, but completed the activity independently all other times that week. Or the client is capable of completing the activity independently with only supervision, cuing (reminders), or encouragement. Or the client is capable of completing the activity with only minor assistance from caregivers. The client can also be coded as “Needs Some Assistance” if the client received extensive assistance less than 50% of the time, but was capable of completing the activity all other times during that week.
- **Dependent:** Indicates the client can complete part of the activity, but needs human assistance (hands-on) or verbal directions (continuous step-by-step direction) in relation to the activity 50% of the time. The client can also be coded as “Dependent” if receiving Total Assistance with the activity less than 50% of the time, but was capable of completing part of the activity all other times for that week. Or the client was unable to assist in the activity all seven (7) days.

### **CATEGORY: ADLs**

***You must answer ALL QUESTIONS in this category, regardless of the clients level of ability or inability to perform the tasks listed. Use the following definitions for each of the tasks and to accurately assess the client’s level of ability:***

The ADL self-performance categories measure what the client actually did without assistance in the last 7-14 days, indicating balance between the client’s self-performance and assistance caregivers provided for each activity. The assessor should use professional judgment to determine if the last 7-14 days are representative of the client’s overall ADL ability.

- **Transferring:** Indicates how the client moves between surfaces, i.e., to/from bed, chair, wheelchair, standing position (excludes to/from

toileting).

**Codes:**

- 0 Independent** - Indicates total independence in transferring. If an assistive device is used, the type of device should be identified in the comments section.
- 1 Assistive Technology Only (no help)** – Indicates that even though the person uses a walker, wheelchair, cane, crutches, rails or any other type of assistive device, he/she is totally independent.
- 2 Supervision and/or Coaching** - Indicates that even though the person is independent is transferring, standby supervision and/or direction is necessary for safety.
- 3 Limited Assistance; needs some help** - Indicates direction or guidance is needed for correct positioning of limbs/appliances (, sliding board), for safety, but client can transfer self.
- 4 Extensive Assistance** - Indicates hands-on assistance or continuous step-by-step direction is necessary for transfer; weight bearing includes few weight bearing steps with pivot.
- 5 Total Dependence** - Indicates transfer requires total human support; non-weight bearing or only able to pivot.

If during the assessment, a transfer deficit is the only identified self-performance problem, the effects of the transfer deficit on all other activities of daily living should be carefully evaluated. **Example:** If the client uses a lift chair, assess the ability to transfer from bed, toilet, etc.

- **Walking/Mobility:** Includes ambulation and wheelchair (electric or manually propelled) performance. A client's environment should be considered when evaluating this ADL. A client's endurance should be considered when evaluating the ability to walk or propel a wheelchair.
  - 0 Independent** - Indicates total independence in walking, in wheelchair, or in motor cart (i.e., client who is completely mobile in electric wheelchair). If an assisting device is used, the type of device should be identified in the comment section (i.e., walker, cane).
  - 1 Assistive Technology Only (no help)** – Indicates that even though the person uses a walker, wheelchair, cane, crutches, rails or any other type of assistive device, he/she is totally independent.
  - 2 Supervision and/or Coaching** - With or without assistive device indicates intermittent supervision may be needed with ambulation or wheelchair use. Example: Slow gait but steady.
  - 3 Limited Assistance; needs some help** - Indicates guidance is needed for correct positioning of limbs/appliances (e.g., braces,

prosthesis) or assistance is needed in difficult wheelchair/ambulation maneuvers (awkward thresholds, crowded areas, elevators/stairs, uneven pavement, outside) or for safety with ambulation/wheelchair. The client has the capacity to ambulate or propel wheelchair independently to a destination (more than 20 feet).

- 4 **Extensive Assistance** - Indicates the need for physical assistance with ambulation; this need includes unsteadiness with ambulation, assistance with the application of a brace or prosthesis without which a client could not walk. If a client is wheelchair bound, it indicates physical or verbal support is needed for wheelchair use. It also indicates necessary extensive continuous verbal/hands-on direction to prevent wandering, whether because of the client's habitual tendency or his/her inability to find strategic locations (i.e., bathroom, dining room). Wandering indicates non-goal directed locomotion.
  - 5 **Total Dependence** - Indicates a client's total inability for walking, even though the ability remains to stand and bear weight or, if wheelchair bound, indicates total inability to operate or manually propel the wheelchair.
- **Dressing:** Assessment should focus on the client's ability to dress self
    - 0 **Independent** - Indicates the client is totally capable of dressing without assistance.
    - 1 **Assistive Technology Only (no help)** – Indicates that even though the person uses a walker, wheelchair, cane, crutches, rails or any other type of assistive device, he/she is totally independent.
    - 2 **Supervision and/or Coaching** - Indicates oversight or reminders are needed for dressing.
    - 3 **Limited Assistance; needs some help** - Indicates help is needed with zippers, buttons, shoes, laying out of clothes, etc.
    - 4 **Extensive Assistance** - Indicates the client needs physical assistance or continuous verbal step-by-step directions in relation to appropriate dressing at least 50% of the time. Such assistance may be needed by a client who frequently dresses inappropriately for the physical environment (i.e., many layers of clothes when the temperature does not warrant them).
    - 5 **Total Dependence** - Indicates the client must be dressed by others.
  - **Bathing:** This activity rates the maximum amount of physical assistance the client requires in order to achieve safe and adequate hygiene. Code the maximum amount of assistance client receives. Physical help in part

of bathing activity (washing off) indicates that client needs assistance in a part of the bathing activity at least 50% of the time (excludes washing of back and hair.)

- 0 **Independent** - Indicates no physical assistance or direction is needed with routine daily bathing.
  - 1 **Assistive Technology Only (no help)** – Indicates that even though the person uses a walker, wheelchair, cane, crutches, rails or any other type of assistive device, he/she is totally independent.
  - 2 **Supervision and/or Coaching** - Indicates standby oversight or supervision is necessary to ensure safety and completion, regardless of method of bathing.
  - 3 **Limited Assistance; needs some help** - Physical Help Limited to Transfer Only - Indicates physical assistance is needed to move from one surface to another (example: getting in and out of tub/shower), but no assistance is needed with bathing activity or assistance needed less than 50% of the time (excludes washing of back and hair).
  - 4 **Extensive Assistance** - Physical Help in Part of Bathing Activity - Indicates necessity hands on physical assistance or continuous step by step direction is needed in bathing 50% or more of the time (excludes washing of back and hair).
  - 5 **Total Dependence** - Indicates total hands-on assistance is required in bathing.
- **Eating:** relates to the activities the client is capable of accomplishing within a reasonable length of time for a meal. The amount of food consumed in order to ensure adequate nutritional intake should also be considered.

In the home, "setting up the meal" is defined as a person's ability to take prepared food, warm it and serve it for eating. Since these activities would not be appropriate in nursing facilities or residential care facilities due to licensing and certification standards, facility staff should evaluate client's ability to accomplish these activities.

- 0 **Independent** - Indicates no assistance is needed in setting up and eating the meal. Setting up the meal is defined as a person's ability to take prepared food, warm it, and serve it for eating.
- 1 **Assistive Technology Only (no help)** – Indicates that even though the person uses a walker, wheelchair, cane, crutches, rails or any other type of assistive device, he/she is totally independent.
- 2 **Supervision and/or Coaching** - Indicates oversight or reminders are needed for meal preparation and/or to eat meals.



- 3 **Limited Assistance; needs some help** - Indicates help is needed in cutting meat, opening prepackaged items, and so forth.
  - 4 **Extensive Assistance** - Indicates the need for physical assistance with or continuous step by step directions pertaining to eating and/or setting up the meal at least 50% of the time.
  - 5 **Total Dependence** - Indicates the client is totally dependent on another for feeding.
- **Toilet Use:** Indicate how the client uses the toilet (i.e. commode, bedpan, urinal): transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.

**Note Regarding Ostomy Care:** when assessing a client who has a colostomy or ileostomy, make sure that you query the client/caregiver regarding how the client personally cares for the ostomy. Once you determine the level of ability then apply the appropriate score.

If bowel/bladder training is in progress, indicate this in the comment section of the continence section. If toileting is done at bedside, using bedpan or commode, indicate in the comments section if the client has any measure of independence.

- 0 **Independent** - Indicates that no assistance is required for toileting.
  - 1 **Assistive Technology Only (no help)** – Indicates that even though the person uses a walker, wheelchair, cane, crutches, rails or any other type of assistive device, he/she is totally independent.
  - 2 **Supervision and/or Coaching** - Indicates oversight is needed for safety in toileting.
  - 3 **Limited Assistance** - Indicates help is needed with arranging clothes or emptying bedpan/bedside commode.
  - 4 **Extensive Assistance** - Indicates routine physical or continuous step by step direction for transfer and/or personal hygiene. This may include a person who frequently toilets in inappropriate places (i.e., floor vents, dresser drawers).
  - 5 **Total Dependence** - Indicates total assistance.
- **Bladder and Bowel Incontinence:** These categories are to be used to code the pattern of bladder and bowel continence/control during the last 14-day period. Use the codes provided on the AIM Assessment Form.
    - 0 **Continent**: Indicates complete control. Note: This would be counted as a deficit when indwelling catheter is in place and not self-care.
    - 1 **Usually Continent**: For bladder - Indicates incontinent episodes once a week or less; for bowel - indicates less than weekly



- 
- 2 **Occasionally incontinent**: For bladder-Indicates 2+ times a week but not daily; for bowel-indicates once a week.
  - 3 **Frequently Incontinent**: For bladder-indicates frequent incontinence, but some control, OR if the client is being toileted (extensive assistance) on a regular basis, i.e., every 2 hours; For bowel - incontinence 2-3 times a week.
  - 4 **Total Incontinence**: Indicates no control (or an indwelling catheter/ostomy that controls the client's bladder/bowel (without leakage).

**Note:** If the client is incontinent, but self-care indicated, this does not constitute a deficit.

**Note Regarding Ostomy Care:** when assessing a client who has a colostomy or ileostomy, make sure that you query the client/caregiver regarding how the client personally cares for the ostomy. Once you determine the level of ability then apply the appropriate score.

### **CATEGORY: FINANCIAL**

Again, it is very important that the client answer this question. All information, including income, is held in the strictest of confidence. We ask for this information for the purpose of gathering data so that we can report on the level of need of our client population. A “No” answer indicates the client has a financial need for the question answered.

**NOTE:** Usually a “Yes” answer indicates a problem area. However in the Financial Category it is the “No” answer that indicates a problem. The short-cut corresponds to this peculiarity by inserting a “No” answer in the Assessment Criteria section when you double-click the financial question.

### **CATEGORY: EATING HABITS**

It is important to ask the client each of the questions to ensure accurate information on their eating habits. Please check that your answers make sense when compared to each other. In other words, if you answer “Yes” to “Eats at least one nutritious meal daily”, then you should **NOT** answer “Yes” to “Eats only snacks or whatever is handy” **NOR** should you answer “Yes” to “Eats sandwiches or light meals only”. However, you could still answer “Yes” to “Professional has nutritional concerns.”

**NOTE:** Even though you may be asking some of these same questions again on the Nutritional Assessment, this portion of the Assessment is part of the overall priority score for the client, the Nutritional Checklist questions and answers are NOT part of the calculated Priority Score.

  
**CATEGORY: LIVING ARRANGEMENTS**

Who do you live with and where do you live? It is important to know the kind of living arrangement the client has. This can be a determining factor for the kinds of services placed in the home. Start off by asking the client if he or she lives with anyone. If the response is “Yes” then follow with, “Whom do you live with?” If the client is living alone then the case manager needs to determine if it is a safe environment. **Please choose and answer ONLY ONE of the Living Arrangements question.** If a client lives with spouse, then you will need to determine if the spouse is dependent on the client or not and choose the “spouse - questions” that best applies. If a client lives with spouse AND others, then choose one of the “spouse - questions”.

**CATEGORY: TRANSPORTATION/DRIVING**

A client’s ability to be self-sufficient depends on transportation, especially for those living in rural communities. It is important to ask a client as many of these questions as necessary to determine their transportation needs. If a client cannot get medications or food or keep a doctor’s appointment then his or her health status is at risk. Answer as many questions as are pertinent to this client.

**CATEGORY: CAREGIVER INFO**

Not all clients need to live with someone. On the other hand, there are clients who need in-home caregiving and none is available. It is important to get a response from the client to this set of questions to determine safety and degree of service needs. If the client is living with the caregiver, then the case manager should try to observe the interaction between client and caregiver when possible, the way the client is dressed and groomed, and the condition of the home and/or the room the client resides in most. These observations will determine if the case manager feels that the client is being properly cared for and treated. Answer as many questions as are pertinent to this client.

**CATEGORY: HEALTH and SAFETY LIMITATIONS (Falls)**

This is an important category particularly if the client is living alone. A fall can be the beginning of a dangerous downward health spiral. If the client is falling in the presence of a caregiver, then there are additional factors that the case manager must take into consideration. When probing for this question, ask the client if they have experienced any falls in the last 30 days, 6 months, and year. If the answer is yes to any of the time frames, then ask how many falls. Answer with number of falls in the last year.



## **CATEGORY: HEALTH PROBLEMS**

It is important to ask the client about any current diagnosed health problems as listed on the Health Assessment Limitations sheet. Tell them you will need information on his or her current health problems and you will be asking about different types of conditions that present current limitations; such as current treatment for heart/circulation problems, high blood pressure, and so on. The only answer choices are “yes” or “no”. Each assessment will now contain only the current conditions that are placing limitations on the client at the time of the assessment. Please answer the health problems logically.

## **CATEGORY: NUTRITIONAL SCREENING**

This category determines if the client is receiving adequate nutrition. Ask the client each question, instructing them to answer yes or no. If you, the assessor, are uncomfortable asking the questions the way they are currently worded, then simply reword the question, just don't change the intent of the question. For example: One of the current questions is “Do you eat few fruits per day?” Reworded, you could say “Do you eat very many fruits each day?” But be careful of the new answer: The current question, answered “Yes”, and the reworded question, answered “No”, imply the same condition: not enough fruits are being eaten each day. You will still need to code the answer in **AIM** according to the original question. So the answer to the question in the example that you would select in **AIM**, would be “**No**”.

**Note:** *Each of these questions must be answered so that the Nutrition Score can be accurately calculated for **AIM** reports.*

## **CATEGORY: END OF RISK SCORE QUESTIONS**

There are, of course no questions and answers in this category. It exists to mark the place where the Priority Score STOPS scoring answers to assessments. It does NOT indicate that no more questions need to be answered. The questions below this category are very important in determining a clients' level of infirmity as well as identifying trends in similar health problems. The information collected in the Nutritional Screening Category, which follows below, is required data for reporting to the federal Administration on Aging through the annual NAPIS report.



  
**CATEGORY: LEGAL SUMMARY**

Many clients do not understand the differences between a “**living**” will and a “**legal**” will and the importance of both. Nor do they understand the need for a durable power of attorney and a health care power of attorney. Anyone conducting an assessment should be familiar with the definition of all of these and be able to refer the client and/or family to someone in the aging community for free advice or assistance if needed.

Answer “**Yes**” if the client has a document. Answer “**No**” if the client does not have a document. ***Use the following definitions to determine which documents a client has:***

- **Living Will:** a document that states how a person wishes to be treated, if he/she becomes incapacitated by illness, injury or old age.
- **Legal Will:** a legal declaration of how one wishes one’s possessions to be disposed of after one’s death.
- **Durable Power of Attorney:** a written power of attorney which contains the words “This power of attorney shall not be affected by my disability,” or “This power of attorney shall become effective upon my disability,” or similar words. In order to be valid it must be signed before the person becomes disabled. The function of a durable power of attorney is to eliminate the need for conservator ship or guardianship proceedings in a court of law should a person ever become incapacitated and unable to manage their own decisions. The person chosen to act on your behalf is called you attorney in fact. This person should be someone you completely trust. The law gives the person choosing someone to act on their behalf the power to impose reasonable limitations and guidelines on the actions.
- **Health Care Power of Attorney:** a document that you, “the principal,” created by appointing another person, the health care “agent” or “attorney in fact,” to make health care decisions for you should you become incapable of the decision themselves.
- **5 Wishes:**

**CATEGORY: RESIDENCE**

This section should be completed every time the client is assessed. A “**Yes**” answer indicates that NO problem exists. A “**No**” answer indicates that a need exists. These “questions” relate to environmental factors which relate to the client's residence. Use the Comments Section if further explanation or clarification is needed.

Once you have completed this Assessment, **click Close**.

The screenshot shows a remote desktop connection to a web-based assessment tool. The window title is "aim.sabersite.com - Remote Desktop Connection". The application title bar reads "AIM Hosted: User is Acting as provider... Lieutenant Governors Office on Aging - [New Record]". The interface includes a menu bar (File, Edit, Locate, Screens, Options, Window, Help) and a toolbar with various icons. The main form contains fields for patient information:

- SSN: AN0-01-80540
- Last Name: [Empty]
- First Name: [Empty]
- Middle Name: [Empty]
- Assessment Date: 02/22/2013
- Next Assess Date: 08/21/2013
- Assessment Type: 2013 Assessment
- Spouse SSN: - -
- Spouse Name: [Empty]
- Assessor: [Dropdown]
- Operator: [Dropdown]
- Medicare #: [Empty]
- Doctor Name: [Empty]
- Doctor Phone 1: ( ) - [Empty]
- Doctor Phone 2: ( ) - [Empty]
- Medicaid #: [Empty]
- Lock Assessment Answers

Below the form is a table with the following data:

Category	Question	Answer
IADLs	Preparing Meals	Independent
		Needs Some Assistance
	Light Housekeeping	Dependent
		Independent
	Heavy Housekeeping	Needs Some Assistance
		Dependent
	Telephone Use	Independent
		Needs Some Assistance
	Money Management	Dependent
		Independent
	Shopping	Needs Some Assistance
		Independent

At the bottom of the interface, there are buttons for "General", "Medical", "Medication", "View Graph", "Category Scores", and "View Criteria". A status bar at the very bottom indicates "aim - Retrieve Data: Retrieve Complete!: 0 Rows Retrieved".



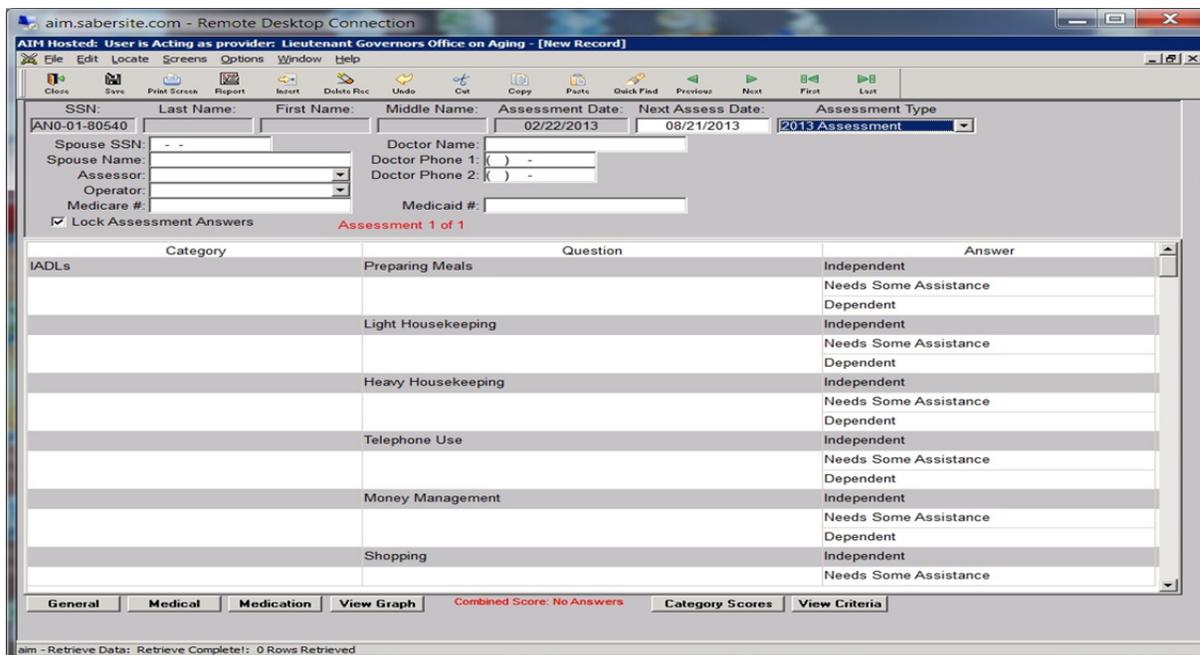
## PART B Updating an Existing Assessment

There are times when minor information on an existing assessment needs to be corrected or updated.

**Note:** If a client's condition has significantly changed, a **NEW** assessment (i.e. a re-assessment) should be performed, rather than updating an existing assessment, even if it has not been a year since the last assessment.

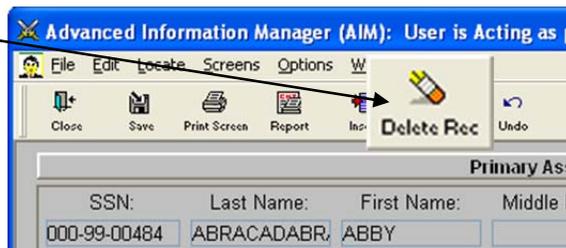
In the case where minor information needs to be updated or corrected, bring up client on the Client Screen and then click on the Assessment Quick Link button.

1. **The Most Recent Assessment** will display, which is where corrections or updates should be entered.
2. **Click** on (to highlight it) any data field in the **Primary Assessment Box** that needs to be updated.
3. Modify the information as needed. For example, if the client's doctor has changed, **double-click** on (or **click and drag**) the name to highlight it, and then type in the new name.
4. Uncheck "Lock Assessment Answers" box in order to change answers on the assessment.
5. Click the Category that contains the information that needs to be corrected.
  - a. **If** there is an additional question that needs to be answered, follow the instructions for inserting questions and answers at the beginning of this chapter.



- b. If there is a **Question-Answer** pair that already exists, but needs to be corrected:
  - i. **Click** on the existing **Question-Answer** pair in the **Assessment Criteria for Primary Assessment** box.
  - ii. **Click** the “**Delete Rec**” icon.

- c. Enter the correct Question-and-Answer, following the instructions for inserting questions and answers at the beginning of this chapter .



- 6. Follow instructions in Part A to select appropriate categories, questions, and answers.

**!!CAUTION!!** BE SURE that the **BOTTOM SECTION** of the Assessment Screen—**Assessment Criteria for Selected Category Section**—is **highlighted in green** BEFORE clicking the Delete Rec Button, or you could wind up deleting your entire Assessment!

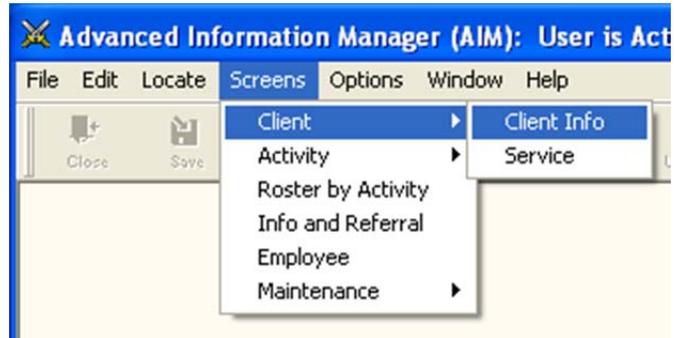
**NOTE:** Again, if you are updating, rather than correcting information in the Assessment Criteria area, you should probably be performing a full re-assessment, rather than updating an existing assessment, even if it has not been a year since the last assessment.



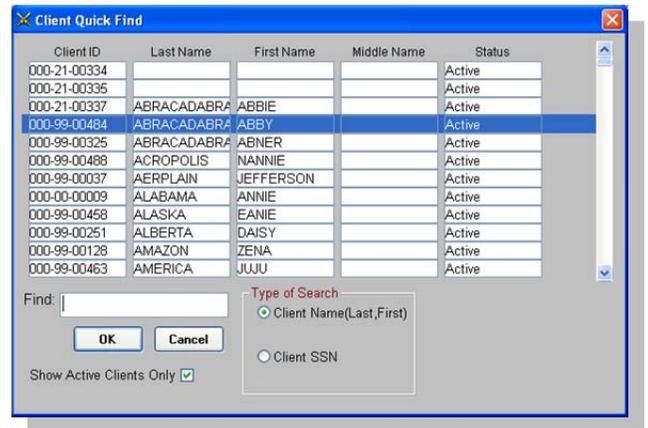
## PART C Deleting an Assessment Record

Deleting records may only be done by the System Administrator. An assessment record should only be deleted when an assessment has been entered on the wrong client or has been entered with the wrong Assessment Date. (Example: someone loads Mary Smith’s assessment data into Mary Jones’ client record; or an Assessment Date of 11/10/2204 was typed instead of 11/10/2004)

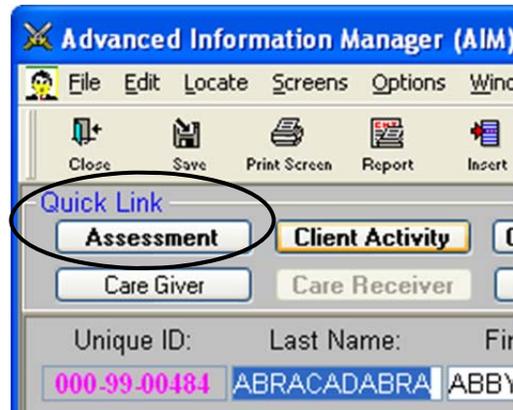
1. Access the **Primary Assessment Information** screen for the client whose assessment data must be deleted:



- a. Click Screens, then Client, then Client Info.
- b. In the Quick Find window, select client for whom you need to delete an assessment.

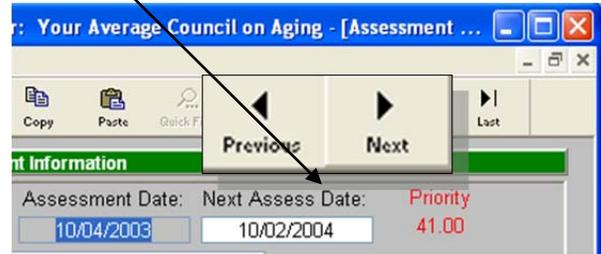


- c. Click the **Assessment Quick Link** Button).

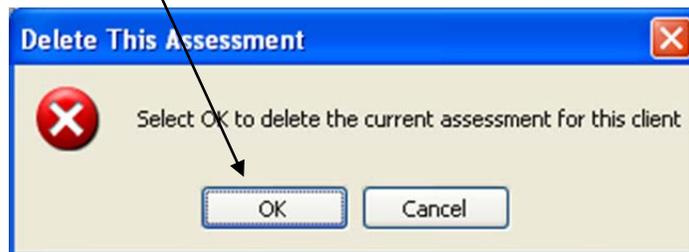


2. When you click the Assessment button, if multiple assessments exist for a client, then the assessment dated LATEST will display first. It is possible you will need to click the “**Previous**” or “**Next**” buttons to find the Assessment you wish to delete.

**NOTE:** This can be VERY confusing, because the “**Previous**” button moves you to LATER assessments for this client and the “**Next**” button moves you to EARLIER assessments for this client.



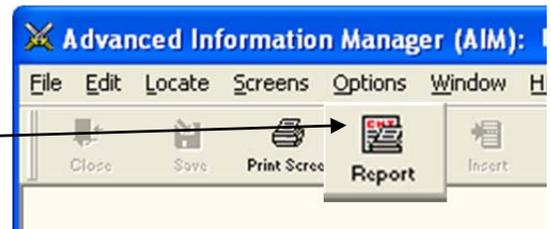
3. The **Primary Assessment Information** bar must be **green**. **Click** anywhere in the upper part of the screen to make sure the bar is green.
4. **Click** on the “**Delete Rec**” icon. The message window, “**Delete This Assessment,**” will pop-up.
5. **Click OK** to confirm that you wish to delete this assessment from the client’s record.



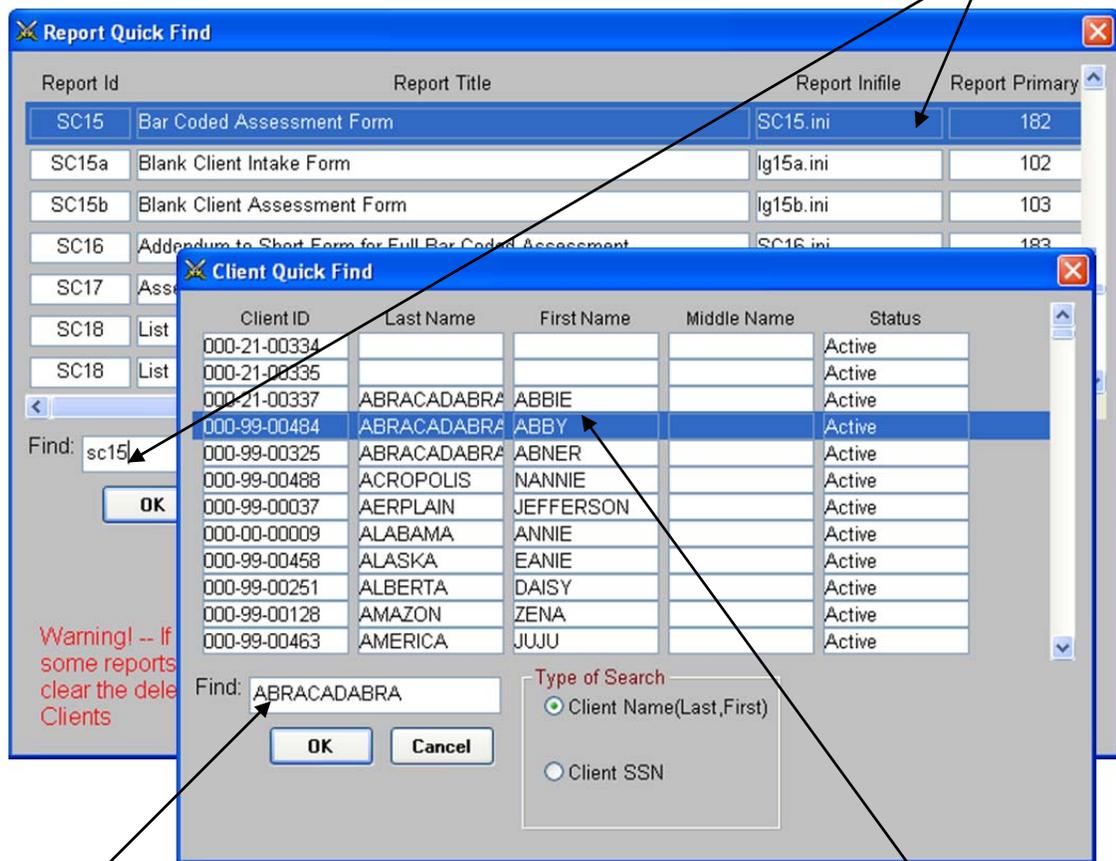
## PART D Using the Bar Code Scanner to Enter Assessment Data

### Creating Bar Coded Assessment Forms

1. First, you need to print out a report form with assessment barcodes on it: Click on the **Report** icon on the top menu.



2. The Report Quick Find window will appear.
3. **Scroll** down to, or **type** in, **SC15** and **double-click** on report row. The **Client Quick-Find** screen will appear for you to select a client for whom you will be performing an assessment.



4. **Type** in the client's last name, then select the correct client from the list, by **Double-clicking**.

- The **Bar Coded Assessment Form** will appear, with the information from the Client screen already filled out.

**Bar Coded Assessment Form**  
Your Average Council on Aging

SSN: 000-99-00484    Name: ABBY ABRACADABRA    Race: Other    DOB: 12/15/1929    Sex: Female    Assess Date:

DOB Verification: \_\_\_\_\_  
E Contact Phone: (803)555-0484  
E Contact Name: MR. & MS. E. COI  
E Contact Relationship: SON  
Case Worker: Caseworker Suzie  
Doctor Name: DR.DOCTOR  
Doctor Phone: \_\_\_\_\_

Marital Status: Married    Spouse: \_\_\_\_\_  
Address: 717 SOME OTHER AVE.  
Mailing Address: \_\_\_\_\_  
METROPOLIS, SC 29991  
County: 28    Rural Yes    Region: 6  
Home Phone: (803) 555-0484    Consent Release: No

Employment Status: Retired

Client Income:    Client Expenses:    Client Assets:

Job: \$ \_\_\_\_\_    Home / Rent: \$ \_\_\_\_\_    Home: \$ \_\_\_\_\_  
Social Security: \$ \_\_\_\_\_    Utilities: \$ \_\_\_\_\_    Automobile: \$ \_\_\_\_\_  
SSI: \$ \_\_\_\_\_    Food: \$ \_\_\_\_\_    Savings: \$ \_\_\_\_\_  
VA: \$ \_\_\_\_\_    Transportation: \$ \_\_\_\_\_    Furniture: \$ \_\_\_\_\_

Printer Setup    Criteria    Export Report    Print    Cancel

aim - Retrieve Data: Retrieve Complete! 1 Rows Retrieved

- Move the cursor to the bottom of the screen and **Click "Print."** This process prints a 15-PAGE form for the selected client with basic information pre-printed on the form, as well as all of the categories, questions, and answers in the assessment criteria section in bar-coded form.

**Note:** If you cannot see the buttons at the bottom of the screen, you need to HIDE your Task Bar (The Print button and the others are BEHIND the Task Bar).

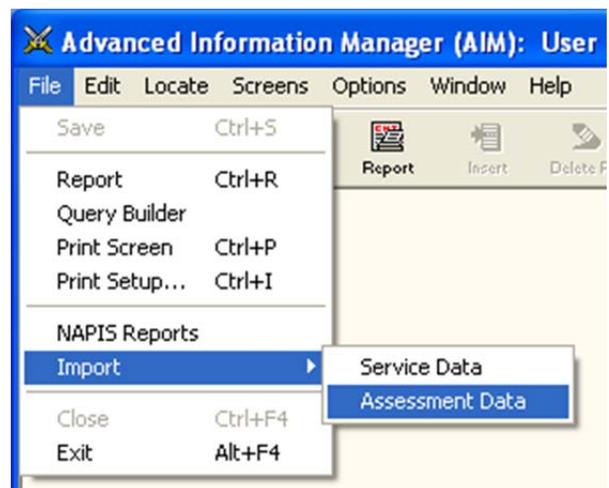
- The client assessment can be completed by circling with pen or pencil, using a highlighter pen, or otherwise indicating the correct response directly on the form. Take care not to put ink or pencil marks on the bar coding.

**Assessment Categories, Questions and Answers**

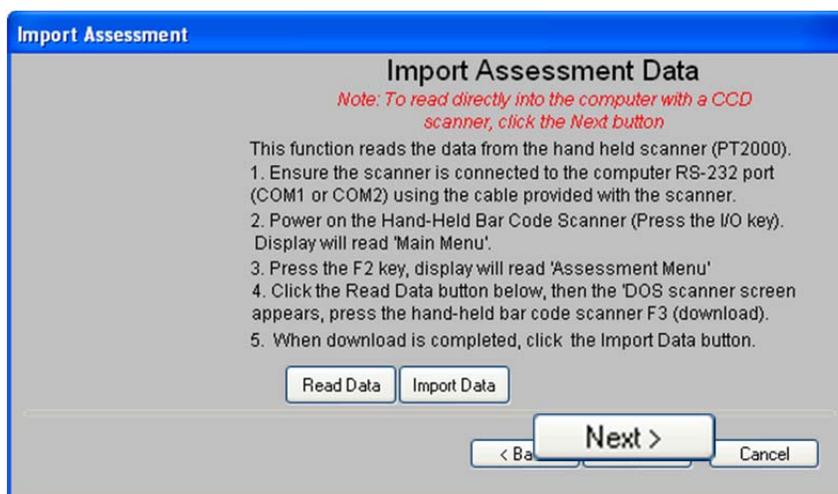
Services Requested		Services Requested	
Information and Assistance	Yes	Home Care	Unmet Need
99Q1A1		99Q6A457	
99Q1A2	No	Home Delivered Meals	Yes
99Q1A455	Unmet Need	99Q7A7	
Congregate Meals	Yes	99Q7A8	No
99Q5A3		99Q7A458	Unmet Need
99Q5A5	No	Transportation	Yes
99Q5A456	Unmet Need	99Q8A9	
Home Care		99Q8A10	No

**Note:** highlighter pens do not harm the bar coding, and can be used directly on the bar code.

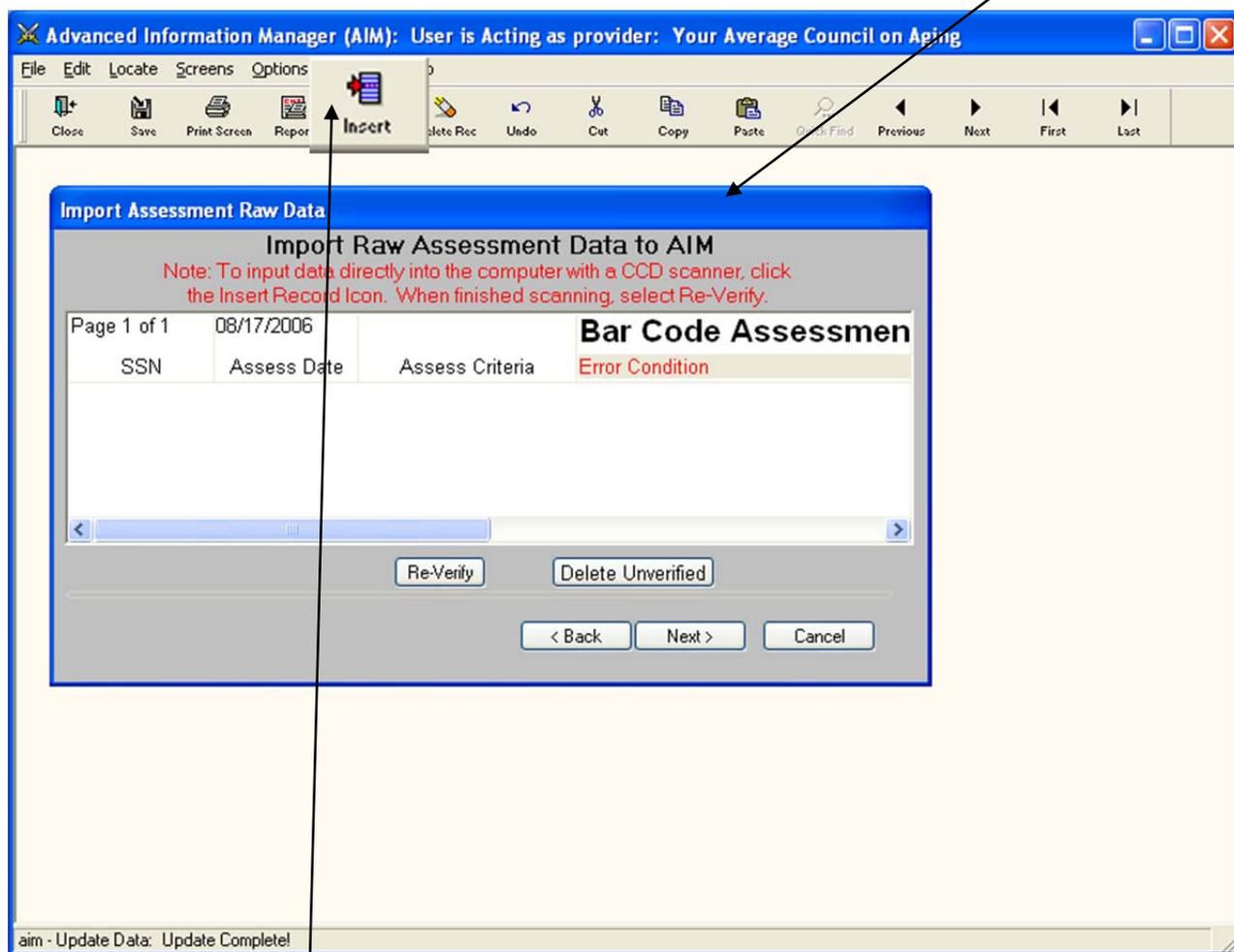
- To enter bar coded assessment data into **AIM**, the scanner must be attached to the computer. (See **Chapter III (3)**, the last page, for installing a bar code scanner to your computer).
- From the **AIM** menu, **Click File**, then **Import**, then **Assessment Data**.



10. The **Import Assessment Data** window will appear. **Click Next.**



11. The **Import Assessment Raw Data** screen will appear.



12. **Click** the **“Insert”** button to enter the first assessment answer.

13. The cursor will be positioned in the **SSN (client identifier)** field. **Scan** the client's identifier from the assessment form, or type it in.

**Note:** the "SSN" entered must be EXACTLY the same as the "SSN" in the client's record. If it is not, you must update the Client Information screen before you can put in the assessment data.

14. **Click** on the **Assess Date** field.

15. **Type** in the date of the assessment (in the form of mm/dd/yyyy), or **scan**

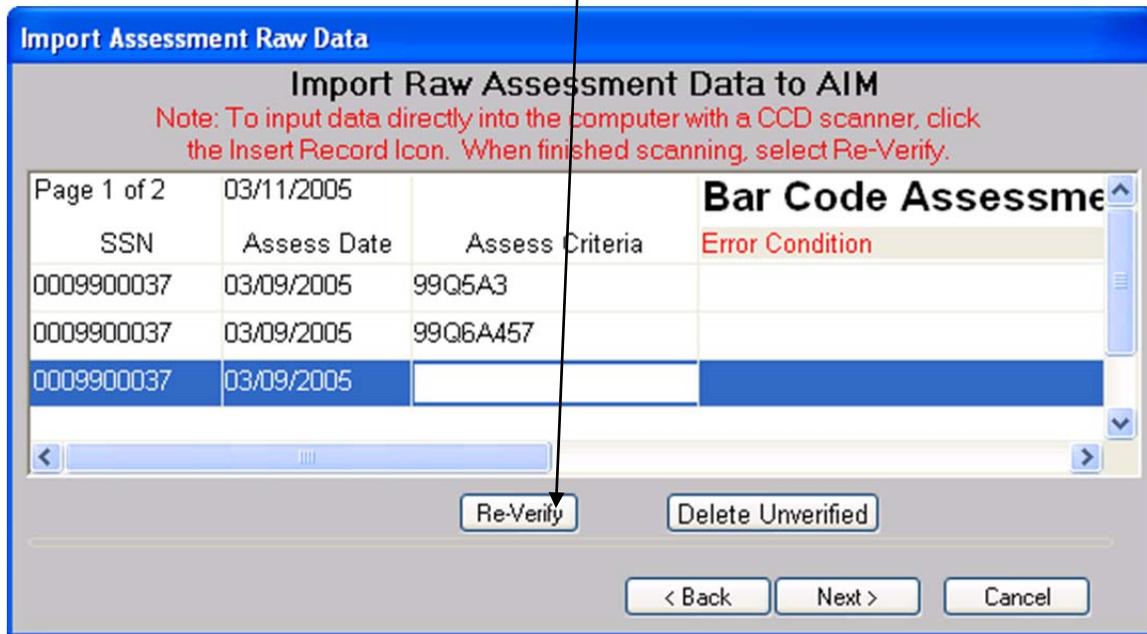
it in from a bar-coded “Dates” form.

16. Click or <Tab> to the **Assess Criteria** field.

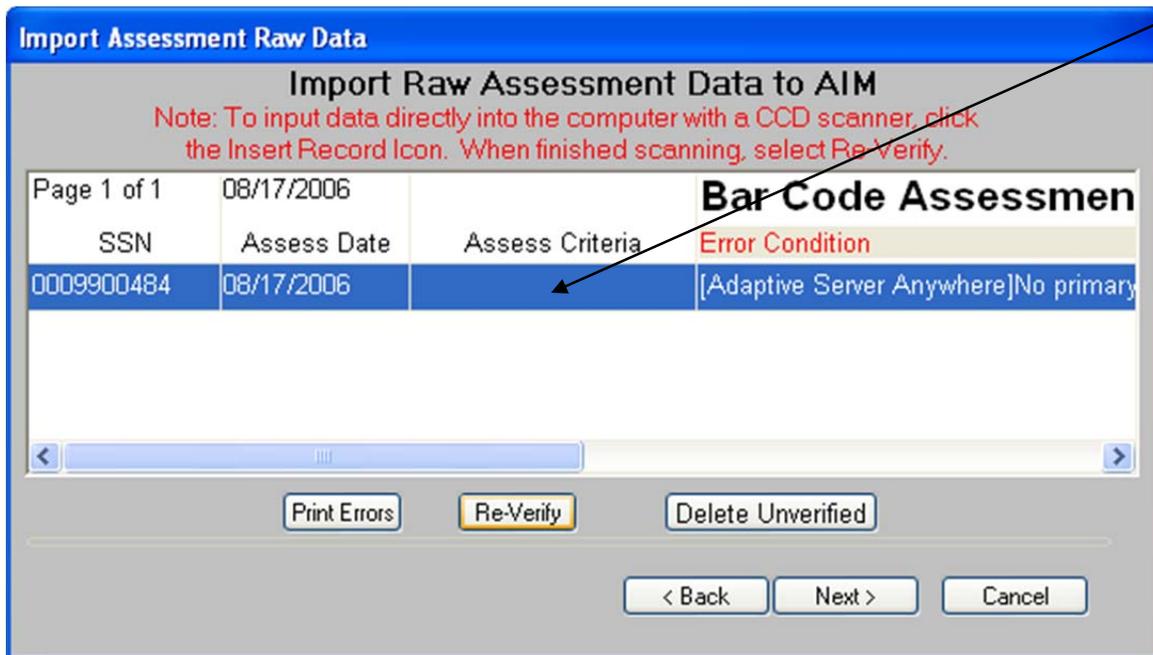
17. **WITH THE CAPS-LOCK OFF, Scan** the first answer from the bar coded assessment form.
18. The screen automatically creates the next line, automatically filling in the client’s SSN and Assess Date and ready for entry of the next answer.
19. Continue scanning all answers until finished.

Assessment Categories, Questions and Answers			
<b>Services Requested</b>		<b>Services Requested</b>	
Information and Assistance		Home Care	
99Q1A1	Yes	99Q6A457	Unmet Need
99Q1A2	No	Home Delivered Meals	
99Q1A455	Unmet Need	99Q7A7	Yes
Congregate Meals		99Q7A8	No
99Q5A3	Yes	99Q7A458	Unmet Need
99Q5A5	No	Transportation	
99Q5A456	Unmet Need	99Q8A9	Yes
Home Care		99Q8A10	No

20. When you have finished scanning all answers from all pages of the Bar-Coded Assessment Form, **Click on the Re-Verify button in the Import Assessment Raw Data window.**



21. The rows will disappear one by one as they are verified to have a valid SSN, Assess Date, Assessment Answer, and are not duplicate entries.  
 22. There will always be one row left after all other rows have disappeared.



**NOTE:** Even if all data entered is correct and valid, after the Re-Verify process finishes, you will have one row left, containing an error. This is not a true error, just a blank row. So you may simply delete it.

**Import Assessment Raw Data**

**Import Raw Assessment Data to AIM**

Note: To input data directly into the computer with a CCD scanner, click the Insert Record Icon. When finished scanning, select Re-Verify.

Page 1 of 1	08/17/2006		<b>Bar Code Assessment</b>
SSN	Assess Date	Assess Criteria	Error Condition
0009900484	08/17/2006		[Adaptive Server Anywhere]No primary

Print Errors   Re-Verify   Delete Unverified

< Back   Next >   Cancel

23. Any error in scanned data will appear in the window. You may make corrections at this time by typing over incorrect information or deleting duplicate rows (See the error message interpretation in the next step). If corrections are made, select the **Re-Verify** button. If no corrections are made, and an error report is desired, **click the Print Errors** button.

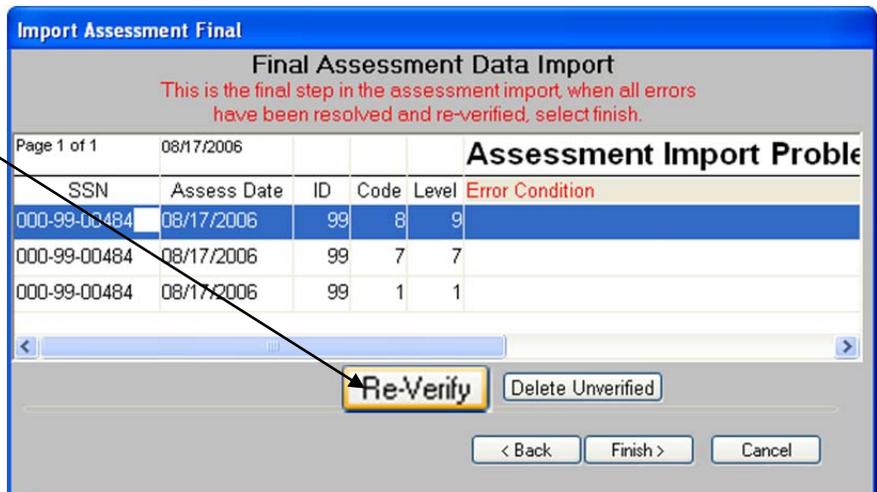
24. Though the Error messages may seem daunting, they can be very easily interpreted. Simply skip over the words “[Adaptive Server Anywhere]” and look at the message following (you will need to scroll to the right to read the entire message): the most common messages have the meanings as follows:

Error Condition says...	Interpretation...
no primary key value for foreign key 'id_choice' in table 'assessment_interim'	The code is wrong in the <b>Assess Criteria</b> column. The most common error is either a blank line, or the Q's and A's are lower case, instead of upper case (To scan them in Upper Case, TURN OFF Caps Lock.)
no primary key value for foreign key 'client' in table 'assessment_interim'	The <b>SSN</b> for the client is incorrect. There is no such SSN for any client in the database.
primary key value for table 'assessment_interim' <b>is not unique</b>	That particular Assessment Answer for that particular client on that particular date <b>ALREADY exists</b> in that client's assessment. Either you scanned the same bar-code twice, or if you have lots of these messages, then that client has an assessment for that date in the already in the system.

25. Try to correct the data, if possible. If any remaining data cannot be corrected, you may delete it by **clicking** on the **Delete Unverified** button.

26. Once there are no more rows showing, Click **Next**.

27. On the **Final Assessment Data Import** screen, you will see all your rows of verified data, again, in a slightly different format. Don't make changes from this screen. Just **Click Re-Verify**.



28. One by one, the rows will again disappear. At this point, it is possible you will again get error messages. If you do, the screen will jump back to the bar-code scanning screen, where you can correct or delete the erroneous rows. Once you have Re-Verified the corrected rows and deleted any left over rows, you will be returned to the **Final Assessment Data Import** screen.
29. **Click Re-Verify** again and all the remaining rows should disappear.

Import Assessment Final

**Final Assessment Data Import**

This is the final step in the assessment import when all errors have been resolved and re-verified, select finish.

Page 1 of 1      08/17/2006      **Assessment Import Problem**

SSN	Assess Date	ID	Code	Level	Error Condition

Re-Verify      Delete Unverified

< Back      **Finish >**      Cancel

30. **Click the Finish** button.
31. The **Import Assessment** window will disappear and you be back to a blank **AIM** screen.
32. To check the assessment you entered, you can run the **LG52** report "Data for a Single Client." (See **Chapter X**, for how to run different reports.)

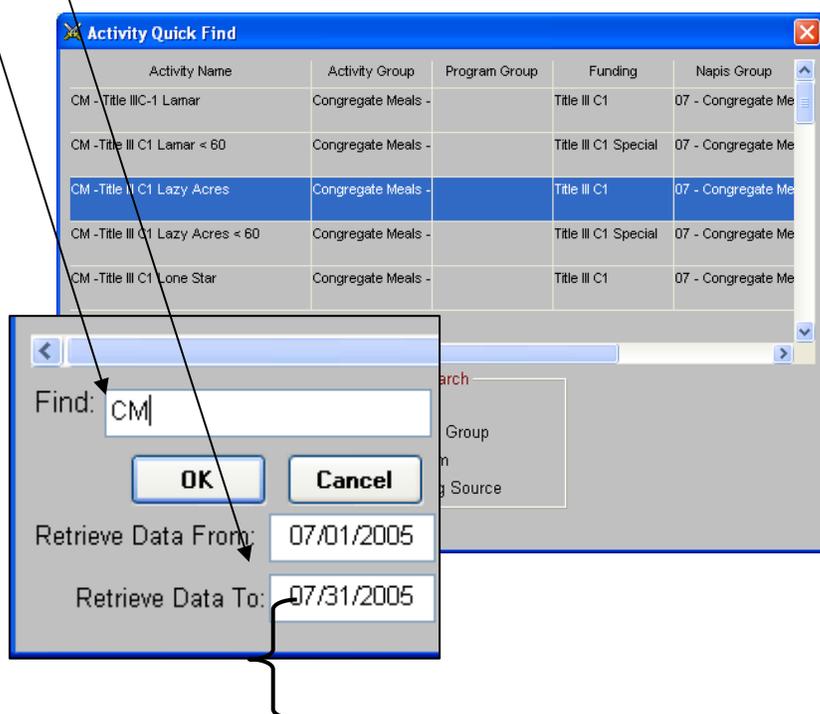
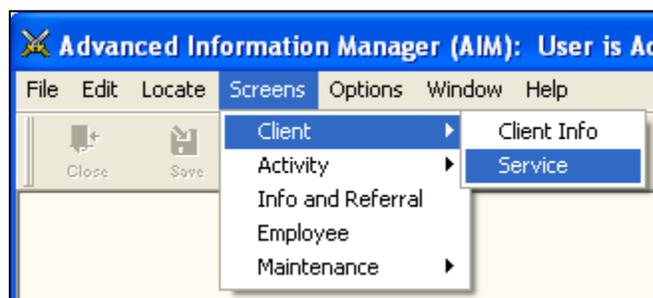
## Chapter V ACTIVITY DATA (Service Units)

Activity input in **AIM** consists of crediting units of service to individuals served by the provider. There are four (4) ways to enter activity data:

- Entry by a specific service (i.e., activity)
- Entry by a specific client
- Entry by scanner wand using the bar-code scanner and printed bar-coded rosters
- Entry by keyboard using the bar-code scanner screens

### PART A: Entering Activity Units from the Service Screen

1. Click on **Screen**, then **Client**, then **Service**.
2. The **Activity Quick Find** screen will appear.
3. Enter the **date range** for which you plan to enter units.
4. Type in the **Find** box the first few letters of the Facility providing the service which you will be entering units. **Scroll** to, the Funding, Activity (Service).
5. **Double-Click** on the Activity to begin entering units (or Single-Click on the Activity and then **Click OK**).



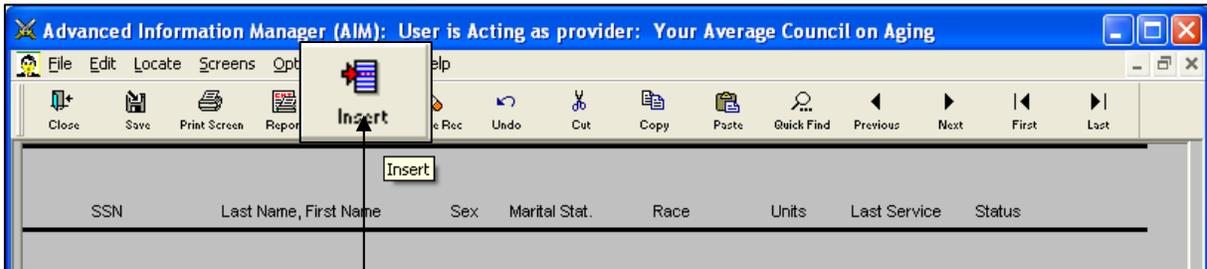
- If no Activity units have been entered, for this Activity, during the date range specified, as yet, a window will pop-up asking if you want **AIM** to display a blank screen where you can start entering units of service. (If units have previously been entered for this service, they will display in place of the blank window.)



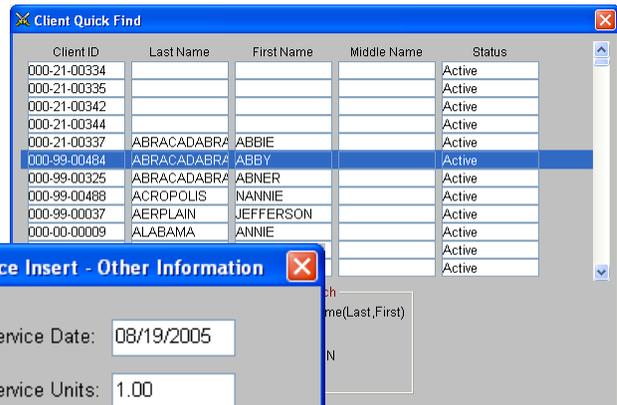
- Click **“Yes”**, if you get the pop-up Question, otherwise proceed to the next step.

**NOTE:** The name of the Activity you selected will NOT show as yet on the Activity Screen, so be CERTAIN that you selected the Activity you meant to select.

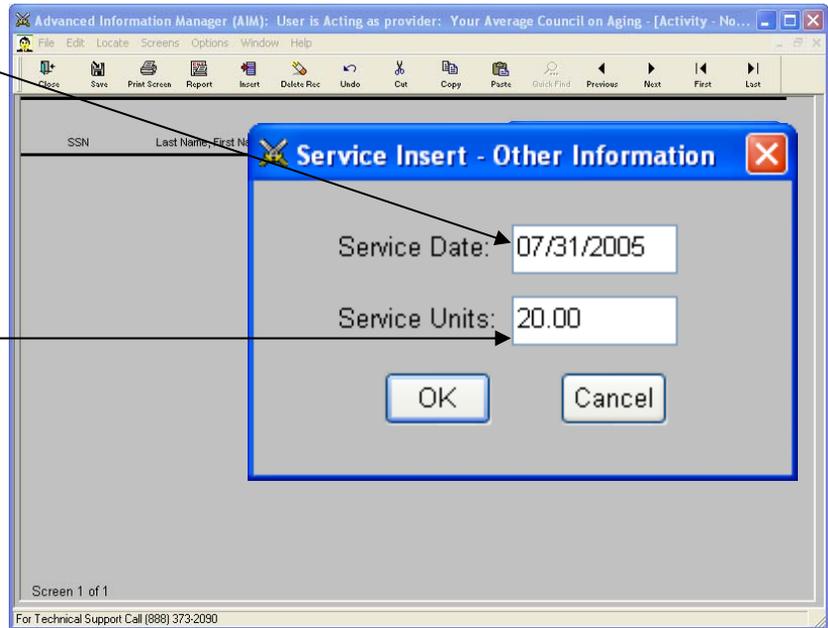
- The **Activity Screen** will be displayed.



- Click the **Insert** icon from the menu bar. The **Client Quick Find** screen will appear.
- Double-click** the first client's name for which you are going to enter units. The **Service Insert** screen appears, pre-set with today's date and 1.00 Service Unit.



11. Click on the **Service Date** field and enter the date for which you are posting units.
12. Click on the **Service Units** field and enter the number of units you are posting.
13. Click **OK**.
14. The client's name and some demographic information will display, along with the date, number of units, and Activity name.



SSN	Last Name, First Name	Sex	Marital Stat.	Race	Units	Last Service	Status
000-99-00484	ABRACADABRA, ABBY	Female	Married	2 or more Race	20.00	07/31/2005	Active

15. Continue steps 9 -14 until you have entered all clients (records) for that Activity (service).

SSN	Last Name, First Name	Sex	Marital Stat.	Race	Units	Last Service	Status
000-99-00484	ABRACADABRA, ABBY	Female	Married	2 or more Race	20.00	07/31/2005	Active
000-99-00458	ALASKA, EANIE	Female	Married	White	20.00	07/31/2005	Active
000-99-00399	BELARUS, LULU	Female	Widowed	African Americ	20.00	07/31/2005	Active
000-99-00465	KAZAKHSTAN, MONIE	Female	Married	White	20.00	07/31/2005	Active
000-99-00358	OREGON, MONIE	Female	Widowed	African Americ	20.00	07/31/2005	Active
000-99-00011	SLYHERIN, LULU	Female	Single	African Americ	20.00	07/31/2005	Active

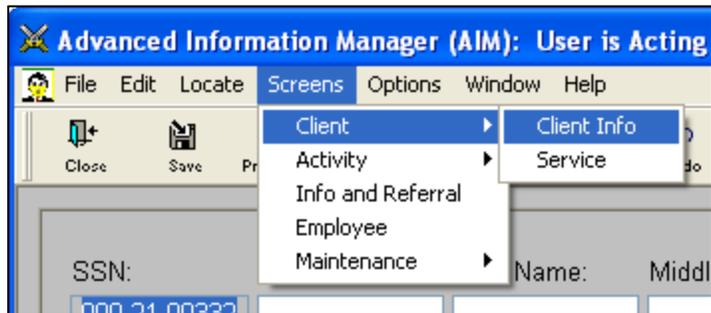
- If you exit from the Activity Screen and then go back in, choosing the Activity and data range for which you just entered units, the name of the Activity will display. You can also balance from this screen, as it keeps a running total of the units entered (see screen above).

**NOTE:** There are several different strategies for entering service units, all of which are acceptable:

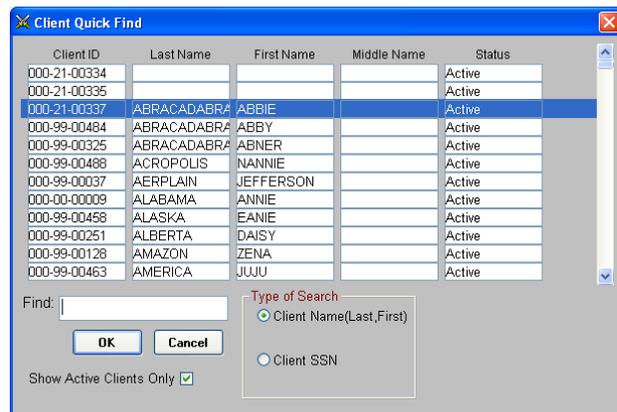
- Monthly:** Using this method, you enter the total units of service a client received for the month and you use the Last Day of the Month of service for the date of posting. This is useful if you use Monthly Service Rosters to record clients' units of service.
- Weekly:** Using this method, instead of waiting until the end of the month to enter units, you tally them up weekly by client and you use the Last Day of each of the Weeks of service for the dates of posting. This is useful if you use Weekly Service Rosters to record units of service.
- Daily:** Using this method, you enter exactly how many units of service a client received on each day the client received service. This is useful if you want daily tallies to be able to track client participation frequency.

## PART B Entering Activity Units from the Client's Activity Screen

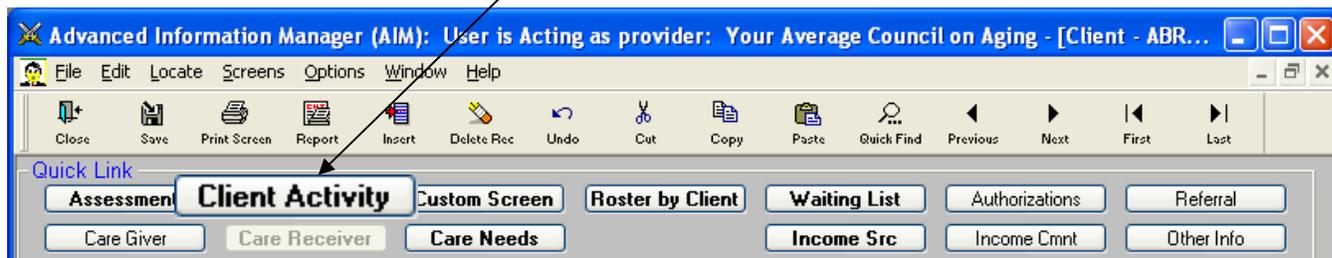
- Click on the **Screens** menu item, then **Client**, then **Client Info**.



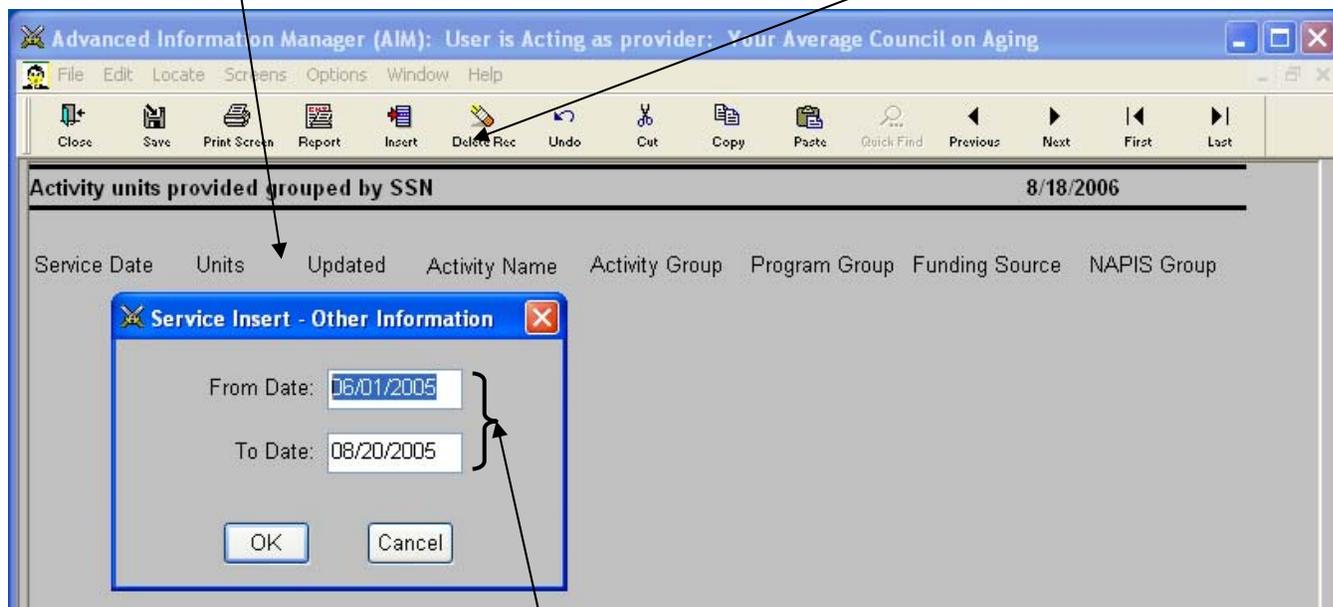
This will bring you to the **Client Quick Find** screen.



2. **Type** in the last name of the client for whom you are entering units of service, then scroll to find the correct client and **double-click** on the name.
3. The **Client Screen** for that client will display.
4. Click on the **Client Activity** Quick Link button.

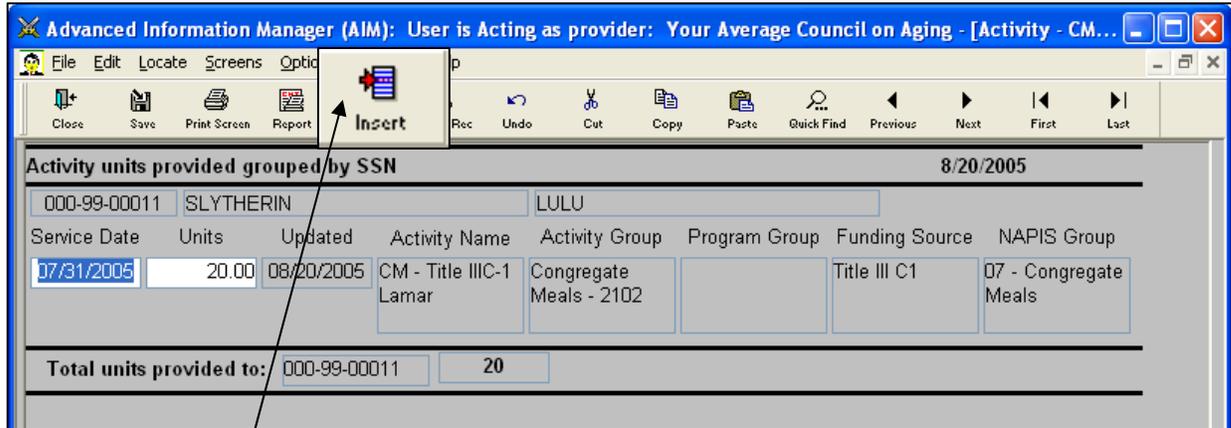


5. The “**Activity units provided grouped by SSN/Unique Identifying Number**” screen will appear with a “**Service Insert – Other Information**” window on top.



6. Enter the date range for which you are posting units of service for this client and **Click OK**.

- The Activities that have been posted for the client and date range specified (or a blank screen if no units exist) will display.



- Click **Insert** to begin entering units for this client.

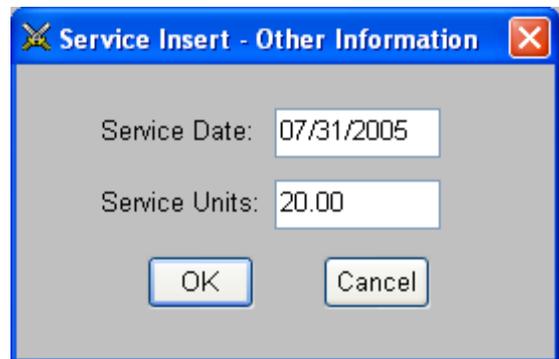
- The **Activity Quick Find** screen will appear.



- Type** in the **Find** box the first few letters of the Facility providing the service for which you will be entering units. **Scroll** to Funding, Activity (Service).

- Double-Click** on the Activity to begin entering units (or Single-Click on the Activity and then **Click OK**).

- A **Service Insert** window will pop-up.



- Double-click** on the “**Service Date**” field to highlight it, then **Type** the **Date** for which you are posting units.

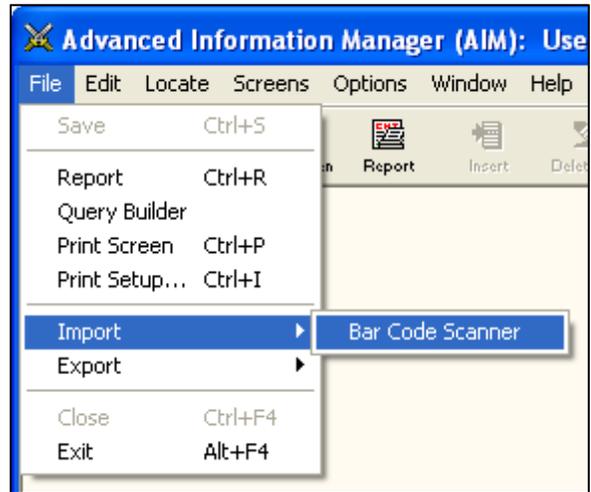
- Double-click** on the “**Service Units**” field to highlight it, then type in the number of units for the activity you are posting.

- Click OK**.

- To enter another activity, **click** on the **Insert** icon again and follow steps 7-14 above until all activities for this client have been posted.

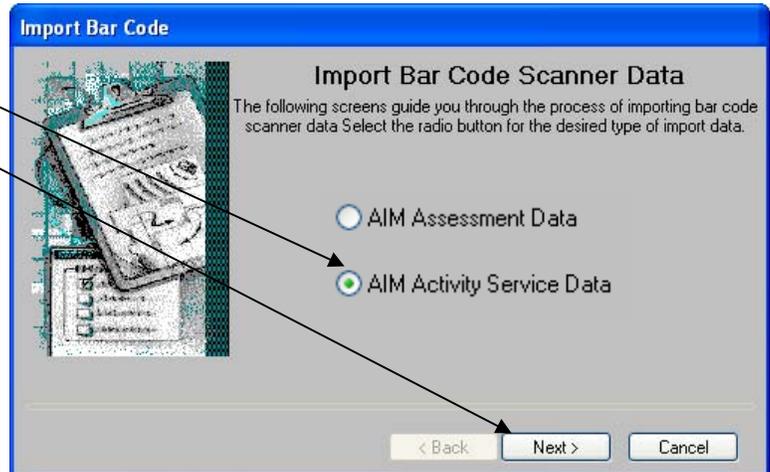
**PART C: Entering Activity Units from the Bar Code Scanner Screens**

1. Click on the **File** menu item, then **Import**, then **Bar Code Scanner**.



2. The **Import Bar Code Scanner** window will appear.

3. Click **AIM Activity Service Data**.

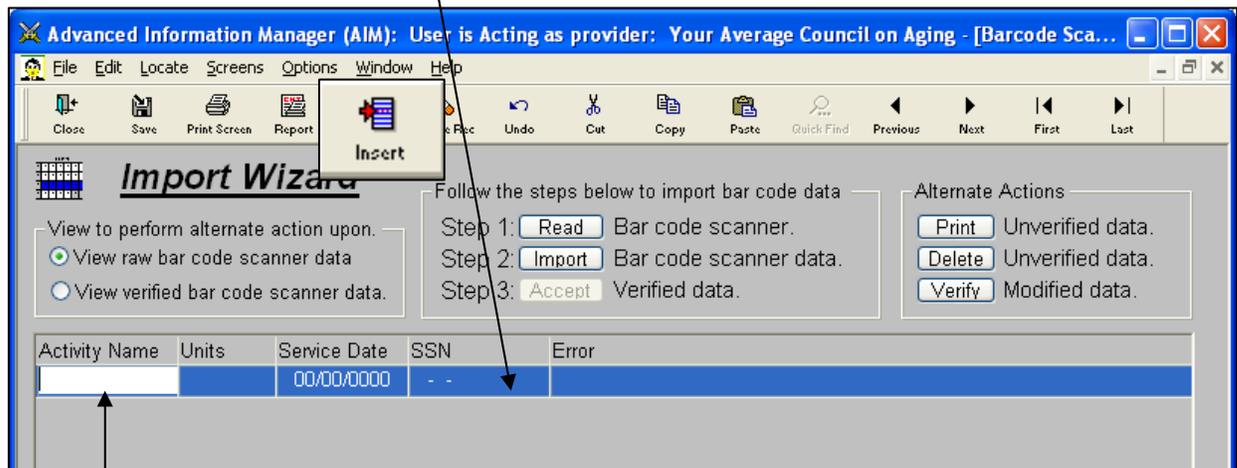


4. Click **"Next."**

The **Import Wizard** screen will appear.

5. Click on the **Insert** icon.

6. A blank row will appear across the screen under all columns.



7. Click in the first field under the column headed **Activity**.

- On your **Activity Roster**, position the scanner over the bar code for the **Activity Definition**.

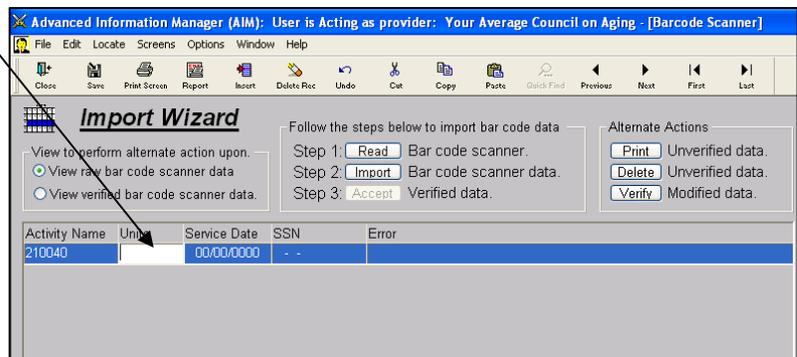
Week 1 2/ 2/ 04 – 2/ 6/ 04

**Activity Roster for: Your Average Council on Aging**  
 Act: CM-Lazy Acres Grp: Congregate Meals - 2 Pgm: FS:- Title III C1 NAPIS: 07 - Congregate Meals

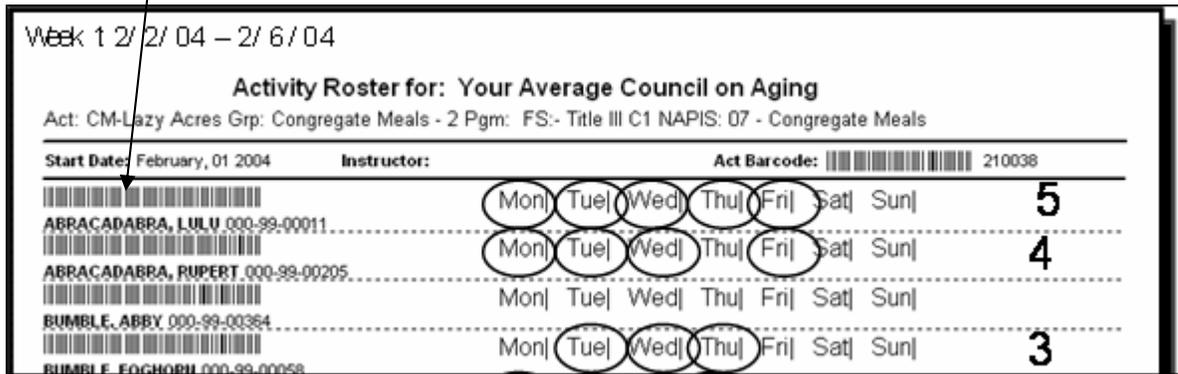
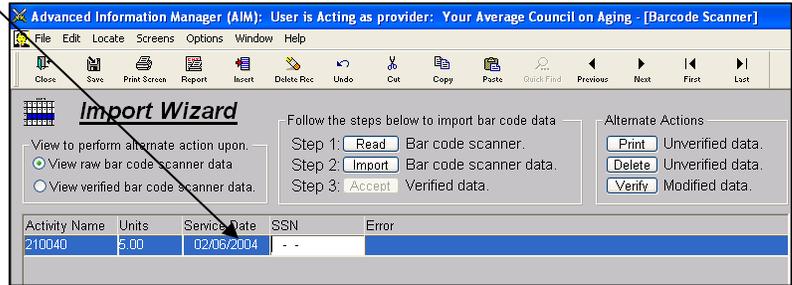
Start Date: February, 01 2004	Instructor:	Act Barcode:	210038
ABRACADABRA, LULU 000-99-00011	Mon  Tue  Wed  Thu  Fri  Sat  Sun	5	
ABRACADABRA, RUPERT 000-99-00205	Mon  Tue  Wed  Thu  Fri  Sat  Sun	4	
BUMBLE, ABBY 000-99-00364	Mon  Tue  Wed  Thu  Fri  Sat  Sun	3	
BUMBLE, FOGHORN 000-99-00058	Mon  Tue  Wed  Thu  Fri  Sat  Sun	2	
BUMBLE, MONIE 000-99-00400	Mon  Tue  Wed  Thu  Fri  Sat  Sun	5	
CARROTTOP, VEIUS 000-99-00180	Mon  Tue  Wed  Thu  Fri  Sat  Sun	4	
DOORIGHT, EBENEZER 000-99-00114	Mon  Tue  Wed  Thu  Fri  Sat  Sun	1	
HOORAY, LULU 000-99-00046	Mon  Tue  Wed  Thu  Fri  Sat  Sun	1	
JEEPERS, JUJU 000-99-00101	Mon  Tue  Wed  Thu  Fri  Sat  Sun	1	
LOVELOBI, VEIUS 000-99-00438	Mon  Tue  Wed  Thu  Fri  Sat  Sun	1	
MONOPOLY, RUPERT 000-99-00185	Mon  Tue  Wed  Thu  Fri  Sat  Sun		

**Note:** the scanner does not need to touch the bar code. The laser beam should be positioned so that it covers the entire bar code to be scanned.

- Pull the trigger on the scanner. The scanner will beep twice, and the activity code will appear under the **Activity**.
- <TAB> to the “Units” field in the **AIM** window.
- Type a “0” for the number of units And <TAB> over to the **Service Date**.



12. Type in the **Service Date** for which you are posting units. And **TAB** over to the **SSN/UIN**.
13. Position the scanner over the bar code for the **“SSN/UIN”** field.

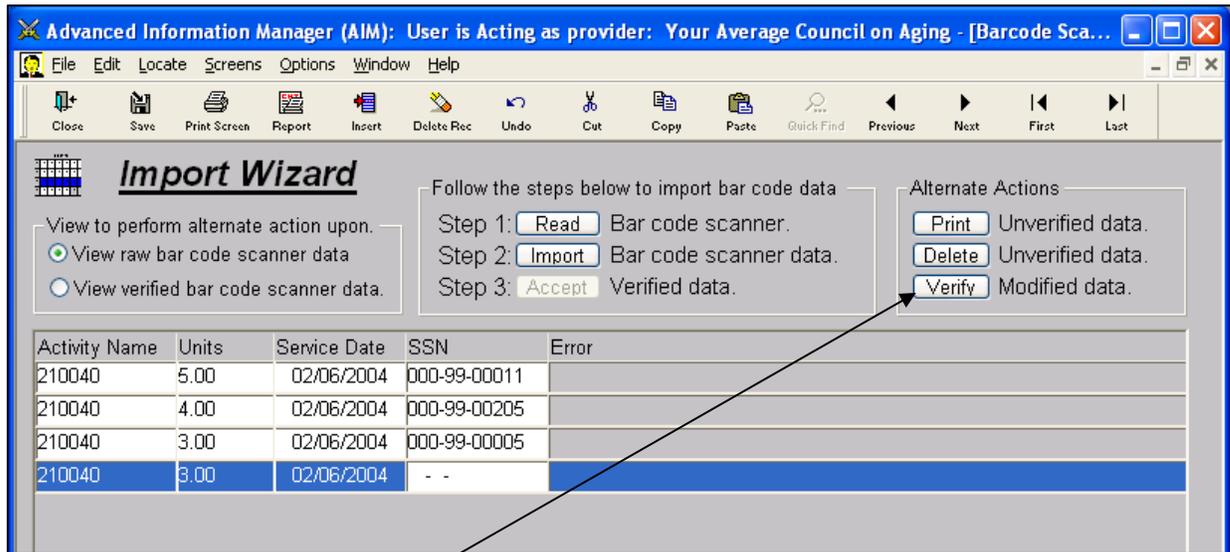


14. Pull the trigger on the scanner. When accepted by the program, the scanner will beep twice, and the client’s SSN/UIN will appear under the **SSN/UIN** column in the **AIM** window.

**NOTE:** It is more efficient to type a “0” for the number for the units (or the most common number of units) and scan all the SSN/UINs with the same number of service units. Then, after the units have been imported, go to the Services Screen, and change the unit numbers to the correct units. (See Below.)

15. At the same time the SSN/UIN appears under the SSN/UIN column, a new row will automatically be inserted with the Activity Code, Number of Units, and Service Date as the row immediately above.

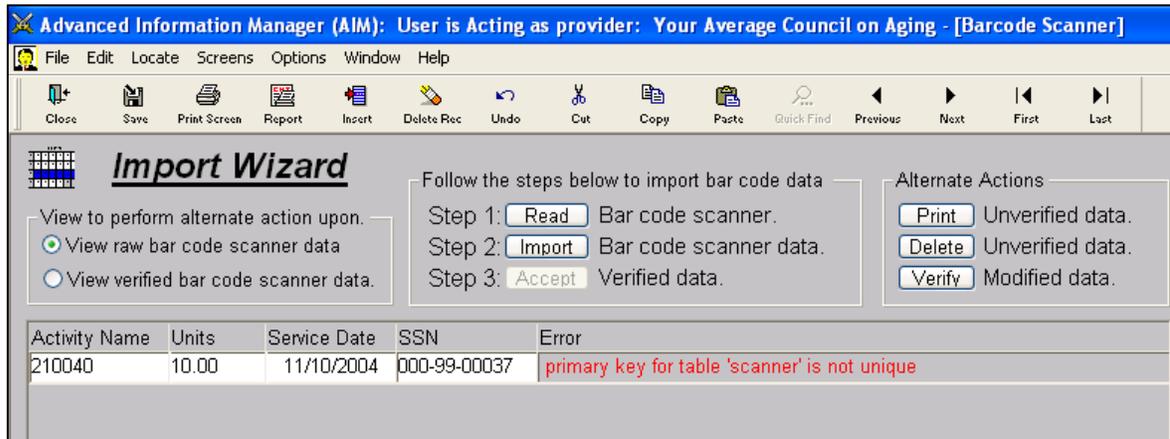
- Continue in this manner until all items on the Activity Roster have been entered.



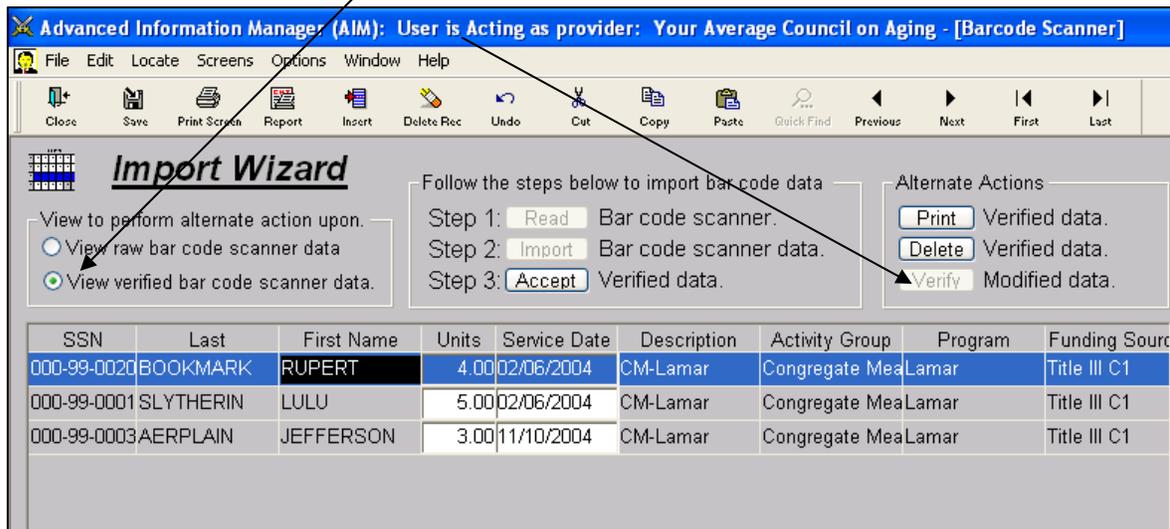
- Click on the **Verify** Button.
- One by one, the rows will disappear, leaving only the rows that have errors (if any).
- Use the chart below to correct errors.

Error Condition says...	Interpretation...
no primary key value for foreign key ' <b>activity</b> ' in table 'scanner'	<b>Activity</b> code is wrong in the Activity Name column. Check the Activity number against the Activity number in the SC39 report.
no primary key value for foreign key ' <b>client</b> ' in table 'scanner'	The <b>SSN/UIN</b> for the client is incorrect. There is no such SSN for any client in the database. Check the SSN/UIN for that client in the <b>AIM</b> Client Screen and correct it.
primary key value for table 'scanner' <b>is not unique</b>	That particular Activity for that particular client on that particular date has <b>ALREADY been entered</b> . Either you scanned the same bar-code twice, or if you have lots of these messages, the service units you are entering are the already in the system.

- After Correcting the rows you can correct, **Delete** the rows that remain by pressing **Delete** Unverified data.



- Click on the **“View verified bar code scanner data”** radio button.



- DO NOT** make any changes from this screen. If you see mistakes on this page, make a note of them and correct the information from the Service Screen.

- Click **Accept** Verified data.



- Again, one by one the rows will disappear.

- 
25. From here, you can either **click Close** to close the Import Service Unit function or you can **click “View raw bar code scanner data”** to and repeat steps 5 – 26.

**NOTE:** If you don't have a bar-code scanner, but you're quick with a number key-pad, you can follow the instructions above, but in place of SCANNING a BAR CODE, you will TYPE the BAR-CODE (the number appears beside the Activity Code and the Client's ID/SSN). Once you have all the information typed in the FIRST line you inserted, simply tap the ENTER KEY on your keyboard and the information will automatically fill in for the next row and be ready for you to TYPE then next client ID/SSN!

# Chapter VI CREATING AND MANAGING ROSTERS

**AIM** has a built-in function for creating and managing client **Rosters**, which can be used to track service units for later data entry. A Client Roster is a Report (Report ID's SC01 - SC03) that lists Clients and days of the week or month for which the service manager can circle days of the week or dates of the month that the clients received services.

Week 1 2/ 2/ 04 – 2/ 6 / 04

**Activity Roster for: Your Average Council on Aging**

Act: CM-Lazy Acres Grp: Congregate Meals - 2 Pgm: FS- Title III C1 NAPIS: 07 - Congregate Meals

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Start Date: February, 01 2004      Instructor:      Act Barcode:  210038

Client Name	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Count
ARRACADABBA, LULU 000-99-00011	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5				
ARRACADABBA, RUPERT 000-99-00205	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4				
BUMBLE, ABBY 000-99-00364	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3				
BUMBLE, FOGHORN 000-99-00058	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2
BUMBLE, MONIE 000-99-00400	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5				
CARROTTOP, VEIUS 000-99-00180	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4
DOORIGHT, EBENEZER 000-99-00114	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1				
HOORAY, LULU 000-99-00046	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1
JEEPERS, JUJU 000-99-00101	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1
LOVELOBI, VEIUS 000-99-00438	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1
MONOPOLY, RUPERT 000-99-00185	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1

The Report determines which clients will show on the Roster, based on this Roster Management tool.

**NOTE:** Only clients with the Status of **ACTIVE** will appear on the Roster Reports (SC01-SC03), REGARDLESS of whether or not they have been selected to appear on the roster on the “**Select Clients for Roster:**” Screen.

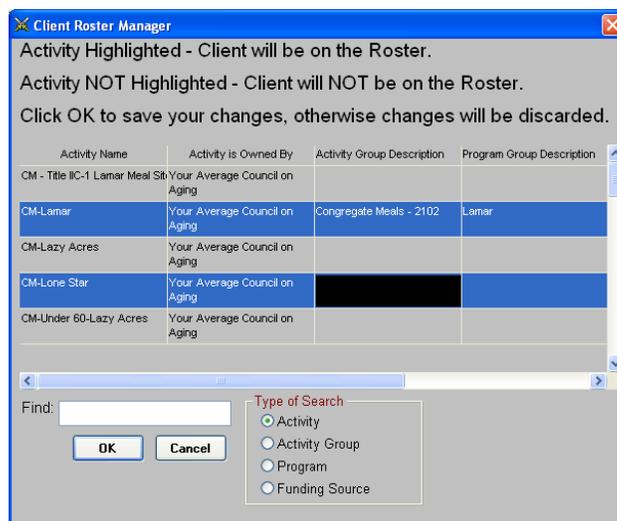
You can manage the Client Rosters in two different areas:

- **One Client on Various Rosters** at the same time from the **Client Screen** as you Insert, Assess, or Change the Status of a Client.
- **Various Clients on One Roster** at the same time from the **Roster by Activity Screen**

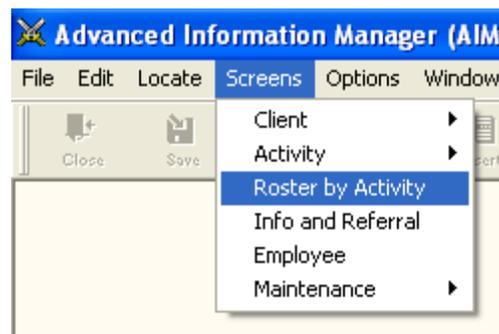


- **From the Client Screen:** Add and Remove clients for various Roster reports by **Clicking** the the **Roster by Client** Button.

A window will pop-up where you can add this client to, or remove this client from, one or more rosters. Using this button, you can add or remove the client from the Roster(s) at the time that you initially enter the client or when you go into the client's record to add a re-assessment or change the status. Simply Click the Activity for which the Client will be added or removed. If the Activity is **highlighted in blue**, the client will appear on the corresponding Activity Roster. If the Activity is NOT highlighted, the client will NOT appear.

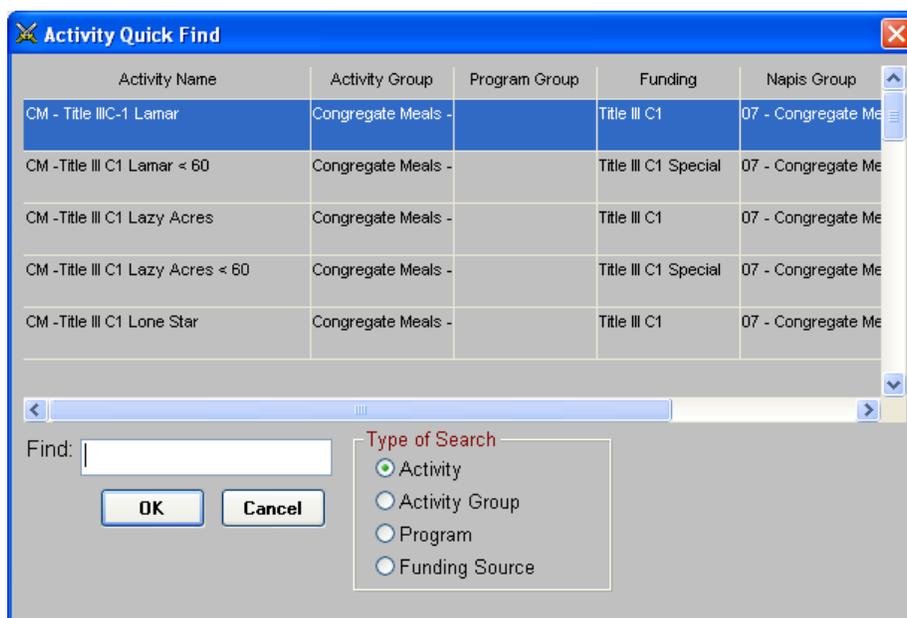


- **From the Roster-by-Activity Screen:**
1. **Click on Screens > Roster by Activity.**



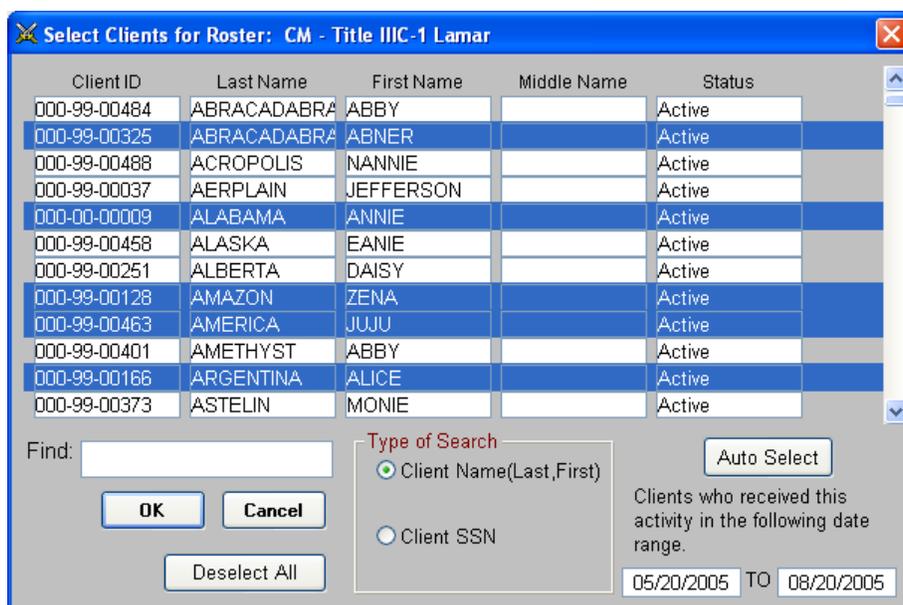
2. The Activity Quick Find Screen will appear.

3. **Click on ONE Activity** for which you wish to create a roster or manage an existing roster



4. The “**Select Clients for Roster:**” screen appears with clients who were previously selected for this Activity highlighted. If you have selected an Activity for which no roster has previously been created, no clients will be highlighted.

5. **Click on the clients** you wish to Add or Remove from the Roster. Those Clients that are **highlighted in blue** will appear on the Roster and those not highlighted will not appear.



6. **OR** you may prefer to have **AIM auto-add** clients to the Roster (or a combination of both methods: auto-add clients and then add/remove clients as needed.)



Client ID	Last Name	First Name	Middle Name	Status
000-99-00484	ABRACADABRA	ABBY		Active
000-99-00325	ABRACADABRA	ABNER		Active
000-99-00488	ACROPOLIS	NANNIE		Active
000-99-00037	AERPLAIN	JEFFERSON		Active
000-00-00009	ALABAMA	JANIE		Active
000-99-00458	ALASKA	EANIE		Active
000-99-00251	ALBERTA	DAISY		Active
000-99-00128	AMAZON	ZENA		Active
000-99-00463	AMERICA	JUUU		Active

Find:

Type of Search

Client Name(Last,First)

Client SSN

Clients who received this activity in the following date range.

TO

- To **Auto Select (ADD ONLY)** clients to the Roster, **Enter a Date Range** for which most of the clients you want to put on this roster have already received the Activity and then **Click** the **“Auto Select”** button. The following message will display.

**Auto Select Process Completed**

Clients that have a row in the service table with a last service date between 12/12/2004 and 03/12/2005 have been selected.

Clients that were already selected were unaffected by the auto select process.

You may now continue to manage this roster, when finished click OK to save your changes or click Cancel to discard your changes.

- If you are starting with a blank roster (or if your roster is way “out-of-whack”), you can **DESELECT ALL** the clients on the Roster and then use the Auto-Add feature to “Refresh the list.”
- Click OK when finished.
- Those are the client that will display on the SC01 – SC03 and the Sign in Sheet LG94.