<u>**ASSESSMENT FIELD EXPLANATIONS**</u>

This is a supporting document for Form: A001 Revision 6/26/13 (Lieutenant Governor's Office on Aging Assessment/Re-Assessment form).

> **NOTE FOR CAREGIVER PROGRAM:** The same assessment tool is used to assess clients (care receivers) and caregivers. In the FCSP, two assessments are completed, one for the CG and one for the CR. Care Receivers are assessed using pages 1-7. Caregivers are assessed using pages 1-2 and 8-9. If the Caregiver is 60 or older, assessment using pages 1-9 is encouraged.

Refused – the client has the right to refuse to answer any question. The refused selection lets the data entry person know the question was not skipped and will serve as backup in the event a client is denied service due to a scoring issue.

GENERAL INTAKE INFORMATION
1. **Initial Contact Date**: Date initial contact was made with the client.
2. **Unique ID#**: System generated number. Will replace the client's SSN.
3. **REQUIRED - Date of Birth**: Required question and is weighted on the assessment under Health and Safety Part 3. Client may Refuse to answer, but it may have an effect on his overall score and services. If the client will only give his age, enter 07/01/yyyy.
4. **Client Type**: Client/Care Receiver or a Caregiver
5. **REQUIRED - County**: County in which client resides.
6. **Region**: AAA Region.
7. **Status**: In order to access the Status and Status Date fields, you must click on the OWNERS screen. 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.

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

- **Active** - For a new client. **Status Date** = effective date client 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.)

- **Closed - Status Date =** date client becomes ineligible for services (date client is terminated).

- **Deceased** - If a client is deceased. **Status Date =** date of death or date agency learned of client's death.

- **Inactive** - If a client becomes ineligible for services, and there is reason to believe this is only a temporary situation. **Status Date** = effective date of ineligibility for services.

- **Pending** - When information on a new client is entered into *AIM* before client is determined to be eligible for services. **Status Date** = date the preliminary information is entered into the system.

- **Pending** - If client is entered onto a Waiting List, BUT NOT receiving any services. **Status Date =** date client was put on Waiting List.

- **Active** - If a client is entered onto a Waiting List, BUT is currently receiving another service. **Status Date** = remains the date client became Active. (The Status Date would NOT change.)

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8. **Status Date**: See above.

SCORES The scores will be generated AFTER the questions are answered in AIM and will automatically populate on the screen. The data entry person will then handwrite the score on this form for the benefit of the assessor.

9. **Assessment Score**: Derived from the Assessment screen on the bottom in red.
10. **Nutrition Score**: Derived from Nutrition questions.
11. **Target Score:** Derived from General Information.
12. **Caregiver Score:** Derived from Caregiver Assessment.

INDIVIDUAL INTAKE INFORMATION

13. **Title**: Optional
14. **Last Name**: Client's last name
15. **First Name**: Client's first name
16. **Middle Name**: Client's middle name. This box can also be used for alias names or individual identifiers
17. **Home Phone**:
18. **Work Phone**:
19. **Cell Phone**:
20. **Email**:

EMERGENCY CONTACT INFORMATION

21. **E Contact Name**: Client's personal contact in case of an emergency
22. **E Contact Phone**:
23. **E Cell Phone**:
24. **E Relationship**: Contacts relation to client
25. **E e-mail**:

INDIVIDUAL INTAKE INFORMATION

26. **Physical Address (Add 1)**: Address where client resides
27. **Apt, Lot, Box (Add 2)**: Additional line for identifying street information
28. **City**:
29. **State**:
30. **REQUIRED - Zip Code**:
31. **Mailing Address if Different (Add 1)**: Address where client receives mail if different than the residential address.
32. **City**:
33. **State**:
34. **Zip**:

OTHER INFORMATION

35. **REQUIRED - Race**: Drop down - select ONE. Client has the right to refuse, however this is a target weighted question.
    African American/Black
    American Indian/Alaskan
    Asian
    Hawaiian/Pacific Islander
    White
    Some Other Race
    2 or more Races
    Race Missing

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36. **REQUIRED - Ethnicity**: Drop down, select ONE. Client has the right to refuse, however this is a target weighted question.
Hispanic/Latino
Non-Hispanic or Non-Latino
Unknown
Refused

37. **REQUIRED - Monthly Family Household Income**: Total household income for EITHER…

a) a single client who lives alone (HH = 1), or

b) the family household income for the client and/or spouse and/or dependent children (HH = # in family dependent upon the client).

You are encouraged to obtain all income sources as this may lead to additional services the client may qualify for. However, if you can only obtain the TOTAL FAMILY HOUSEHOLD INCOME, that is acceptable. Place it in "Income From Other". **Click OK**.

If Client's Income is UNKNOWN and an "educated" estimate is not feasible, refer to the most current HHS Poverty Guidelines. Ask the client for the "Household Size" (number in the household) and then ask if they are below the corresponding 125% (Low 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".

38. **REQUIRED - Total # in Household**: It will either = 1 if the client is single and lives alone. Or, it will = the client plus all family members in household dependent upon him, to include spouse and dependent children.
***INCOME AND #HH should not be entered haphazardly and requires the use of professional judgment.
These two fields are calculated behind the scenes in AIM to determine poverty levels based on the income and household size as set forth in the current year of HHS Poverty Guidelines. In turn, this calculation will be used to determine if your Region is targeting this population. These figures will also be report to NAPIS.

39. **DOB VERIFICATION**: Drop-down. Select how the clients DOB was verified.

40. **REQUIRED - Gender**: Male, Female and Refused.

41. **Marital Status**: Married, Single, Widowed, Divorced, Separated, Unknown and Other.

42. **Monthly Expenses**: Many of the expenses in this section are variables and change from month to month. It is not imperative for you to have the client go obtain current billing statements to gather this information. Reasonable "best estimates" are acceptable. For ex, if they know their power bill runs $120 to $150 a month, you can estimate $135. This section will help prepare the assessor for the ADLs/IADLs by looking for additional assistance for the client.

43. **REQUIRED - Limited English Proficiency**: Yes or No. If NO, you do not need to answer #44 or type English.

44. **Primary Language**: Current options are:

Spanish or Spanish Creole	Korean
French (inc Patois, Cajun)	Italian
German	Japanese

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Chinese   Greek
Tagalog (Philippines)   Arabic
Vietnamese   Gujarathi (India)

None - In the event you enter a language by mistake and want to remove it immediately, you can tab the Undo button on the toolbar. However, if it not noticed until later, select None.

CLIENT's NAME AND UNIQUE ID# - OPTIONAL at the top of each new page. Included at the request of many providers so they can identify client's pages if they become separated.

45. **Special Eligibility**:
Client type = Client - Special Eligibility options would be Client's Spouse, Meal Volunteer, Disabled < 60, Waiver, Emergency.
Client type = Care Receiver - Special Eligibility options would be Disabled < 60, < 18 child or ADRD < 60.
None – During re-assessment, if it is determined the special eligibility status is now None, the system will not allow you to uncheck one box without checking another. So, we have included None so that you can clear out the previous option.
Waiver – Place explanations in the JUSTIFICATIONS comment section.
Other – Place explanations in the JUSTIFICATIONS comment section.
Emergency – Any event that would identify the client as an Immediate At-Risk individual.

46. **Income Comments**: These comments can be viewed by all users. They are comments that may have relevance to the client's income.

47. **Other Information Comments**: These comments can be viewed by all users. They are "catch-all" comments that may have relevance to the client's home directions, which door to knock on, if there are dogs, if there is a smoker in the home, if the assessor should not go alone…. Or any other information that the assessor may want to share with others or for future knowledge.

48. **Assess Date**: This is the date the assessment or reassessment was conducted.

49. **Spouse Name**: Name of client's spouse.

50. **Assessor**: Name of person conduction the interview with the client.

51. **Operator**: Name of the person entering the data into AIM.

52. **Assessment Method**: Was the assessment conducted in person with the client or by phone.

53. **Primary Doctor**: This will be the client's primary doctor, family physician or general practitioner.

54. **Doctor Phone 1**:

55. **Doctor Phone 2**:

56. **Services Requested**: You will check all that apply to the client.

57. **REQUIRED - In the Event of a Disaster**: This is a new section and will be need to assist the client in an event of a disaster. They are Y/N questions.
Type of Transportation Needed: Check only ONE. This determines how a client would be taken out of their home in the event of an evacuation or emergency.

58. **Client Referred by**: Check only ONE. How the client came to our agency.

59. **In-Home Services Currently Receiving**: Check ALL that apply.

60. **Optionals**: Education and Locomotion: Many providers asked that we return these fields for their own information. They are here to help assist you in how to conduct an interview with the client or what type of transportation assistance they may need.

61. **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.

Levels 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.

NEEDS SOME ASSISTANCE – Indicates the client is capable of completing the activity with the assistance of a walker, wheelchair, cane, crutches, rails, or other type of assistive device. 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 is capable of part of the activity, but needs human assistance (hands-on) or verbal directions (continuous step-by-step direction) in relation to the activity 50% or more 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.

- Preparing Meals: Ability to prepare a full, nutritious meal at least twice a day;
- Microwave Use: Ability to operate a microwave.(See page 6 of the Assessment for microwave ownership.)
- Light Housekeeping: 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;
- Driving or Using Public Transportation: Ability to drive a vehicle or able to use public transportation in their area. (See page 4 for Transportation.)

62. 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 client actually did without assistance in the last 7-14 days, indicating balance between 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.

Levels of Ability:

INDEPENDENT - Indicates the client is totally capable of completing the activity without assistance. Indicates no physical assistance or direction is needed with routine daily bathing. Indicates no assistance is needed in setting up and eating meals; to include the ability to prepare food, warm it and serve it for eating.

ASSISTIVE TECHNOLOGY ONLY (NO HELP) – Indicates even though the client uses a walker, wheelchair, cane, crutches, rails or any other type of assistive device, they are totally independent. The type of device should be identified in the comments section.

SUPERVISION AND/OR COACHING – Indicates with or without assistive device, intermittent supervision may be needed with ambulation or wheelchair use. Indicates oversight or reminders are needed for dressing, meal preparation and/or to eat meals and safety in toileting. Indicates standby oversight or supervision is necessary to ensure safety and completion, regardless of method of bathing.

LIMITED ASSISTANCE (SOME HELP) – Indicates direction or guidance is needed for correct positioning of limbs/appliances (eg braces, prosthesis), but can transfer self. Or assistance is needed in difficult wheelchair/ambulation maneuvers or for safety with ambulation/wheelchair. Client has the capability to ambulate or propel wheelchair independently to a destination (more than 20 feet). Indicates needs help with zippers, buttons, shoes, laying out of clothes, cutting meat, opening prepackaged items, and arranging clothes or emptying bedpan/bedside commode. With Bathing, Physical Help Limited to Transfer Only – Indicates physical assistance is needed to move from one surface to another (ex. in and out of shower), but no assistance is needed with bathing activity or assistance needed less than 50% of the time (excluded washing the back and hair).

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), and pertaining to eating and/or setting up the meal at least 50% of the time, and to transfer and/or personal hygiene to include persons who frequently toilet in inappropriate places.
Walking - 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.
Dressing - 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).
Bathing - 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).

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TOTAL DEPENDENCE – Indicates transfer requires total human support: non-weight bearing or only able to pivot. 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. Indicates total hands-on assistance is required in bathing, is totally dependent on another for feeding and toileting.

Codes:
- 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.
- Dressing: Assessment should focus on client's ability to dress self
- Eating: relates to activities 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.
- Toilet Use: Indicate how 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.

- Transferring: Indicates how client moves between surfaces, i.e., to/from bed, chair, wheelchair, standing position (excludes to/from toileting).
- Bathing: This activity rates the maximum amount of physical assistance 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 client needs assistance in a part of the bathing activity at least 50% of the time (excludes washing of back and hair.)
- Personal Grooming: Indicates a need for assistance to take care of grooming and personal hygiene needs, including combing hair, brushing teeth, denture care, shaving, applying makeup, washing/drying face and hands, fingernail care and help with period (menses care). It includes washing hair in the sink at home or in a beauty/barber shop, but does not include bathing or taking a shower.

63. **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.

Note: If 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.

64. **Health and Safety**: This section has been re-written to address <u>CURRENT LIMITATIONS</u> as a result of a Specific Disease or Health and Disability Category. This means they are LIMITED in their daily activities as a result of their condition. Ex. If the individual IS NOT LIMITED by High Blood Pressure, do not check HBP.

    Please refer to the <u>Health Assessment Limitations Due to Any of the Following</u> sheet. If the client has several conditions that fall under one category, they will only receive one check mark for THAT category. However, they can receive a check for more than one category.

65. **# RX Medications**:
66. **# Falls**:
67. **Do you have:**

    Prescriptions from more than one Doctor?

    Prescriptions filled at more than one Pharmacy?

    Nutritional concerns as determined by a healthcare professional?

    Less than a 3 day supply of food on hand?

    Were you seen at the ER or admitted to a Hospital, rehab Facility or NH in the last 6 months?

68. **Do you live with? (All people in same household):**

    An Independent Spouse/Partner/Adult

    1 or 2 Dependent Children < 18

    More than 2 Dependent Children

    Dependent Adult/Spouse/Partner

    Live Alone

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

69. **Where do you live?**

    Boarding Home/Assisted Living/Group home

    Rented Room or Apartment

    Home

    In a Shelter

    Homeless

70. **Transportation**

    Has Transportation – If client has a vehicle they operate.

    Needs Transportation – If client needs to find transportation to get places.

    Needs Transportation and Escort – If client has to find transportation and someone to assist them.

    Needs Specialized Transport – If client needs an ambulance or other specialized vehicle to transport them.

    Client's ability to be self-sufficient depends on transportation, especially for those living in rural communities. Important to ask client as many of these questions as necessary to determine their

transportation needs. If client cannot get medications or food or keep a doctor's appointment, then her health status is at risk. Answer as many questions as are pertinent to this client.

71. Age (from DOB) – Field will be calculated in AIM taken from the DOB
72. Income and Number-In-Household from Client Screen: - Field will be calculated in AIM taken from the Income screen.

In the last 6 months have you:

73. Missed a rent/mortgage payment because you did not have the money?
74. Missed a utilities payment because you did not have the money?
75. Gone without medication because you could not afford it?
76. Gone without food because you could not afford it?
77. How close is your nearest support person?
78. Have anyone you can call if you need help or assistance?

Live 20 or more miles from the following?

79. Shopping (grocery, clothing, personal care items, etc.
80. Pharmacy
81. Your doctor
82. Hospital
83. Have you ever been denied services based on where you live?

Nutritional Screening **http://www.healthcare.uiowa.edu/igec/tools/nutrition/determineNutrition.pdfhttp://www.healthcare.uiowa.edu/igec/tools/nutrition/determineNutrition.pdf**

84. Do you have an illness or condition that has made you change the kind or amount of food you eat?
85. Do you eat fewer than 2 meals a day?
86. Do you eat few (to none) fruits or vegetables, or milk products? This question presents the most problems for providers. The intent of this question is to see if the client has a well-balanced diet to include fruits or vegetables, or milk. It is not looking for a specific number on a daily basis. You want to know if the client has little to none in their diet – if so, answer "yes". If they answer that they eat more than a few, that would be "no".
87. Do you have 3 or more drinks of beer, liquor, or wine almost every day?
88. Do you have tooth or mouth problems that make it hard for you to eat?
89. Do you sometimes not have enough money to buy the food you need?
90. Do you eat alone most of the time?
91. Do you take 3 or more different prescribed or over the counter drugs per day?
92. Without wanting to, I have lost or gained 10 pounds within the last 6 months?
93. Are you sometimes physically unable to shop, cook, or feed yourself?
94. *Homebound: Homebound status is established if an individual resides at home, is unable to drive, does not have access to transportation, and may be at risk for institutionalization.
95. *Living Alone: A one person household where the householder lives by his or herself in an owned or rented place of residence in a non-institutional setting.
96. General Comments: These comments can only be viewed by the owning provider. They are "catch-all" comments.
97. Medical Comments: These comments can only be viewed by the owning provider. They are "catch-all" health related comments.
98. JUSTIFICATION Comments: Section for various justification comments.

CONSENT TO RELEASE INFORMATION May be completed if it fulfills your requirements.

FAMILY CAREGIVER SECTION

1. **How is CAREGIVER related to the CARE RECEIVER? I am the CR's** _____
2. **Does the FAMILY CAREGIVER qualify for respite and other funded services?** Y/N See FORM *Eligibility for Title III-E Services – Family Caregiver*
3. **Does the GRANDPARENT or RELATIVE RAISING A CHILD qualify for funded services?** Y/N   See FORM *Eligibility for Title III-E Services – Seniors Raising Children*
4. **Due to a cognitive or other mental impairment, does the Care Receiver require substantial supervision to maintain their health and safety?** Y/N   See FORM *Eligibility for Title III-E Services – Family Caregiver*
5. **SENIOR is Raising a Child with a severe disability?** Y/N   See FORM *Eligibility for Title III-E Services*
6. **Caregiver has been hospitalized or has visited ER in the past 6 months?** Y/N
7. **Caregiver has not had an annual check-up in the past 6 months?** Y/N
8. **Caregiver has more than 2 limiting current health problems?** Y/N (Use the same criteria as the Health and Safety Section on page 3 of the Assessment and Question 64 explanation above.)
9. **Caregiver has chronic mental health issues?** Y/N
10. **Caregiver household is multi-generational?** Y/N
11. **Caregiver's income has been reduced as a result of caregiving?** Y/N
12. **Caregiver's expenses have significantly increased as a result of caregiving?** Y/N
13. **Caregiver's living arrangements create difficulty in providing care?** Y/N
14. **Caregiver has no one to provide respite/relief?** Y/N
15. **Caregiver has no one to call for help or assistance?** Y/N
16. **Caregiver provides** (blank) **hours of hands on care for Care Recipient per week:** 10-60+ active hours of service to Care Receiver(s).
17. **Caregiver: Is in crisis** Never, Rarely, Sometimes, Frequently, Always
18. **Caregiver: Has a Care Receiver that requires constant supervision** Never, Rarely, Sometimes, Frequently, Always
19. **Caregiver: Feels that because of the time spent with Care Receiver, doesn't have time for self** Never, Rarely, Sometimes, Frequently, Always
20. **Caregiver: Feels stressed between providing care and trying to meet other responsibilities (work/family)** Never, Rarely, Sometimes, Frequently, Always
21. **Caregiver: Feels strained when around relative** Never, Rarely, Sometimes, Frequently, Always
22. **Caregiver: Feels uncertain about what to do about relative** Never, Rarely, Sometimes, Frequently, Always