Lieutenant Governor's Office on Aging Assessment/Re-Assessment

☐ New Client ☐ Annual Reassessment ☐ Significant Change in Condition

Initial Contact Date: _____ Status: _____

Unique ID#: _____ Assessment Score: _____

DOB: _____/_____/_____ ☐ Refused Nutrition Score: _____

Client Type: ☐ Client/Care Receiver ☐ Caregiver Target Score: _____

County: _____Region#: _____ Caregiver Score: _____

Individual Intake Information

Last Name:_____

First Name: _____ Middle Name: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Email:_____

Emergency Contact Information

E Contact Name: _____ E Relationship: _____

E Contact Phone: (___) _____ E Cell Phone: (___) _____ E e-mail: _____

Physical Address: _____

Apt, Lot, Box: _____

City: _____ State: SC Zip: _____

Mailing Address If Different: _____

City: _____ State: SC Zip: _____

Race: (check one) ☐ Refused

- ☐ African American/Black
- ☐ American Indian/Alaskan
- ☐ Asian
- ☐ Hawaiian/Pacific Islander
- ☐ White
- ☐ Some Other Race
- ☐ 2 or more Races
- ☐ Race Missing

Ethnicity: (check one)

- ☐ Hispanic/Latino
- ☐ Non-Hispanic or Non-Latino
- ☐ Unknown
- ☐ Refused

Monthly Family Household Income
(Client, Spouse, Dep. Child)

☐ Refused

$_____Job
$_____SS
$_____SSI
$_____VA
$_____Pension
$_____Other

$_____
Total Family Household Income

Total # in HouseHold: #_____
(Client, Spouse, Dep Child) ☐ Refused

DOB Verification ☐ Marriage Certif
☐ Birth Certificate ☐ Verbal
☐ Driver's License ☐ None

Gender: ☐ M ☐ F ☐ Refused

Marital Status

- ☐ Married
- ☐ Single
- ☐ Widowed
- ☐ Divorced
- ☐ Separated
- ☐ Unknown
- ☐ Other

Monthly Expenses: (best estimate)

$_____ Food
$_____ Prescriptions
$_____ Medigap
$_____ Housing
$_____ Utilities
$_____ Phones
$_____ Other

$_____ Total Expenses

Limited English Proficiency: ☐ Yes ☐ No

Primary Language: _____

Client Name: _____ Uniq ID#: _____

Special Eligibility: ☐ Spouse of Client ☐ Meal Volunteer ☐ Disabled < 60 ☐ Emergency ☐ Other
☐ None ☐ Waiver ☐ < = 18 child ☐ ADRD < 60

Income Comments: (Viewable by all users)

_____
_____
_____

Other Information Comments (Directions, Dog, Smoker, Do not go alone, etc): (Viewable by all users)

_____
_____
_____
_____

Assess Date: _____ Assessment Method: ☐ In Person ☐ By Phone

Spouse Name: _____ Primary Doctor: _____

Assessor: _____ Doctor Phone 1: _____

Operator: _____ Doctor Phone 2: _____

Services Requested: (check all that apply)

- ☐ IR&A
- ☐ Group Meal
- ☐ Home Delivered Meal
- ☐ In-Home Care
- ☐ Transportation
- ☐ Adult Day Care
- ☐ Sitter Service
- ☐ Assisted Transportation
- ☐ Emergency Food
- ☐ Home Injury Prevention
- ☐ Financial Assistance
- ☐ Insurance Counseling
- ☐ Sr. Center Activities
- ☐ Dental
- ☐ Vision
- ☐ Hearing
- ☐ Exercise
- ☐ Nutrition Counseling
- ☐ Nutrition Education
- ☐ Ombudsman
- ☐ Outreach
- ☐ Respite
- ☐ Benefits Assistance
- ☐ Case Management
- ☐ Residential Maintenance
- ☐ Prescriptions
- ☐ Yard Maintenance
- ☐ Legal Assistance
- ☐ Utility Assistance
- ☐ Health Promotion
- ☐ Medical Escort
- ☐ Housing

Client Referred by: (check one)

- ☐ Self
- ☐ DSS
- ☐ AAA
- ☐ Friend
- ☐ Comm Base Org
- ☐ Family
- ☐ Nursing Home
- ☐ Provider
- ☐ CLTC
- ☐ DDSN
- ☐ Hospital
- ☐ Doctor
- ☐ Home Health
- ☐ Other

In-Home Services Currently Receiving:
(check all that apply)

- ☐ CLTC
- ☐ Home Delivered Meal
- ☐ Home Health
- ☐ Homemaker
- ☐ Hospice
- ☐ Transportation
- ☐ VA
- ☐ None
- ☐ Other

IN THE EVENT OF A DISASTER (Required)

Will someone check on you during a disaster? Y or N
Do you have meds that need refrigeration? Y or N
Are you on Oxygen? Y or N
Will you need help during an emergency evacuation? Y or N

Type of Transportation Needed in an Evacuation:
(Check ONE)

- ☐ None
- ☐ Regular
- ☐ Lift Accessible
- ☐ Ambulance

OPTIONALS:

Education:

- ☐ <3rd grade
- ☐ 3rd- 8th grade
- ☐ Some HS
- ☐ HS Grad
- ☐ Some College
- ☐ College Grad

Locomotion:

- ☐ Needs assistance to go outside
- ☐ Unable to climb stairs
- ☐ Uses cane/walker/crutch
- ☐ Uses wheelchair on occasion
- ☐ Uses wheelchair all the time

Client Name: _____ Uniq ID#: _____

IADLS ☐ Refused	Independent	Needs Some Assistance	Dependent
Preparing Meals			
Microwave Use			
Light Housekeeping			
Heavy Housekeeping			
Telephone Use			
Money Management			
Shopping			
Medication Management			
Driving or using Public Transportation			

ADLS ☐ Refused	Independent	Assistive Technology Only (No Help)	Supervision and/or Coaching	Limited Assistance (Some Help)	Extensive Assistance	Total Dependence
Walking/Mobility						
Dressing						
Eating						
Toilet Use						
Transferring						
Bathing						
Personal Grooming						

Continence	Continent	Usually Continent	Occasionally Incontinent	Frequently Incontinent	Incontinent
Bladder Incontinence					
Bowel Incontinence					

Health and Safety Health Limitations Due to the Following(Check all that Apply)	Yes		Yes
Specific Diseases:		**Broad Health and Disability Categories:**	
Alzheimer's, Dementia and Related Disorders (ADRD)		Blood Diseases/Disorders	
Arthritis		Circulatory System/Heart Diseases/Disorders	
Diabetes		Cognitive Diseases/Disorders	
Kidney/Renal Disease/ESRD (End Stage Renal Disease)		Digestive System/Diseases/Disorders	
Cancer		Hearing/Ear Diseases/Disorders	
		Intellectual/Mental Disabilities	
		Mental Illness/Disorders	
		Neurological Diseases/Disorders	
		Physical Disabilities/Diseases/Disorders	
		Respiratory Diseases/Illnesses	
		Speech Disorders	
		Vision/Eye Diseases/Disorders	
		Other Disabilities/Diseases/Disorders	

Client Name: _____ Uniq ID#: _____

Health and Safety (Cont.) Risk Factors Part 1	(Quantity Range)	0	1	2	3-5	6-8	9+
Number of Daily Prescription Medications							
Number of Falls in the Past 6 Months							

Health and Safety (Cont.) Risk Factors Part 2 - Please answer the following Y/N (a Yes response = points)	Y/N
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?	

Health and Safety (Cont.) Risk Factors Part 3					
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
Where do you live?	Boarding Home/ Assisted Living/ Group Home	Rented Room or Apartment	Home	In a Shelter	Homeless
Transportation	Has Transportation	Needs Transportation	Needs Transportation and Escort	Needs Specialized Transport	

In the last 6 months have you: Y/N	Y/N
Missed a rent/mortgage payment because you did not have the money?	
Missed a utilities payment because you did not have the money?	
Gone without medication because you could not afford it?	
Gone without food because you could not afford it?	

Support					
How close is your nearest support person?	< 20 mi	20-30mi	31-50mi	51-99mi	100+mi

Do you:	Y/N
Have anyone you can call if you need help or assistance?	
Live 20 or more miles from the following:	**Y/N**
Shopping (grocery, clothes, personal care items, etc)	
Pharmacy	
Your doctor	
Hospital	
Have you ever been denied services based on where you live?	

Client Name: _____ Uniq ID#: _____

Nutritional Screening Y/N (a Yes response = points)	Y/N	Pts.	Score
Do you have an illness or condition that has made you change the kind or amount of food you eat?		2	
Do you eat fewer than 2 meals a day?		3	
Do you eat a few (or less) fruits or vegetables, or milk products?		2	
Do you have 3 or more drinks of beer, liquor, or wine almost every day?		2	
Do you have tooth or mouth problems that make it hard for you to eat?		2	
Do you sometimes not have enough money to buy the food you need?		4	
Do you eat alone most of the time?		1	
Do you take 3 or more different prescribed or over the counter drugs per day?		1	
Without wanting to, have you lost or gained 10 pounds within the last 6 months?		2	
Are you sometimes physically unable to shop, cook, or feed yourself?		2	
Max Points		**21**	

***REQUIRED QUESTIONS:** (Not Part of Priority Score. For Reporting Purposes)

***Homebound:** ☐ Yes ☐ No

An individual who resides at home, and maybe at risk for institutionalization, and is incapable of performing at least two or more activities of daily living (ADLs) without substantial/extensive assistance, and is unable to leave home unassisted. When the individual does leave home, it must be to receive medical care or for short, infrequent non-medical reasons.

***Living Alone:** ☐ Yes ☐ No

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.

General Comments: (View Restricted to Provider)

JUSTIFICATIONS: (View Restricted to Provider)

Medical Comments (Current and Past Health Conditions): (View Restricted to Provider)

Medication Comments: (View Restricted to Provider)

Client Name: _____ Uniq ID#: _____

Non-weighted questions

Behavior/Psychosocial	YES
Family Caregiver states client has issues with:	
Aggressive behaviors	
Agitation	
Fear/Paranoia	
Hallucinations/Delusions	
Hoarding	
Socially Inappropriate/Disruptive	
Sundown Syndrome	

Residential – Client Has:	YES
Safe access to all necessary areas	
Access to working laundry/washer	
Adequate cooling & heating	
Adequate electricity	
Adequate plumbing	
Animal/Pest control	
Essential repairs/replacements	
In-home safety items	
Security (window and door locks)	
Working microwave	
Working refrigerator/freezer	
Working stove	
Personal Emergency Response System	

Level of Activity	Yes
No Activity/Bedridden	
Moves around the house	
Walks in yard	
Walks in Neighborhood, Mall, Park, Gym, etc.	
Goes places (Shopping, etc.)	
Exercises at home once a week	
Exercises at home 2 or more times a week	
Exercises at Sr. Center, Church, Gym, etc. once a week	
Exercises at Sr. Center, Church, Gym, etc. 2 or more times a week	

Benefits (Currently Receiving)	YES
Medicare	
Medicaid	
Medigap	
Private Health	
Social Security	
SSI	
Food Stamps	
Rental Assistance	
Fuel Assistance	
No Health Insurance	
VA Benefits	
Other	

Client Referred to (Check all that apply)	YES
CBO	
CLTC	
COA	
DDSN	
DHEC	
DHHS	
DMH	
DSS	
Home Health	
Hospital	
Housing	
Legal/SC Bar	
Physician	
VA	

Legal Summary	Yes
Legal Will	
Living Will	
Durable Power of Attorney	
Health Care Power of Attorney	
5 Wishes	

CONSENT TO RELEASE INFORMATION

Last Name: _____

First Name: _____

Middle Name: _____

The information on this form is required by the local provider, the Area Agency on Aging (AAA), the South Carolina Lieutenant Governor's Office on Aging and the U. S. Federal Government. The information provided will be kept confidential and guarded against unofficial use.

Some of the information gathered may be used to refer or provide appropriate services for client (such as referral for other services, emergency contact or sharing pertinent information to related service agencies for the purposes of planning services to meet the needs of the client.)

My information may be used to arrange for these services: ☐ **Yes** ☐ **No**

Some of the data asked for is required by either the South Carolina Lieutenant Governor's Office on Aging and/or the U. S. Federal Government, as entities funding the services, and will be used for reporting and research. This data will not include the client's name or identifying information and is aggregated. A client has the right to REFUSE to provide information. However, by refusing to answer particular questions, the client may be waiving his/her right to receive certain services.

My information may be shared with the entity(ies) funding my service(s): ☐ **Yes** ☐ **No**

Client Signature: _____ Date: _____

If read to client, by whom : _____ Date: _____

Relation: _____

Assessor Signature: _____ Date: _____

Services you will receive:	Date Service Starts:	Frequency of Service:
____ Congregate Meals	_____	_____
____ Home Delivered Meals	_____	_____
____ Transportation	_____	_____
____ Homemaker	_____	_____
____ Other _____	_____	_____

FAMILY CAREGIVER/RECEIVER ASSESSMENT

How is CAREGIVER related to the CARE RECEIVER?

(I am the CR's _____)

- ☐ Husband
- ☐ Wife
- ☐ Son/Son-In-Law
- ☐ Daughter/Daughter-In-Law
- ☐ Other Relative
- ☐ Non-Relative
- ☐ Relationship Missing
- ☐ Grandparent
- ☐ Other Elderly Relative
- ☐ Other Elderly Non-Relative

Does the FAMILY CAREGIVER qualify for respite and other funded services?

☐ Yes ☐ No

Does the GRANDPARENT or RELATIVE RASING A CHILD qualify for funded services?

☐ Yes ☐ No

Screening Y/N (a Yes response = points)	Y/N
Due to a cognitive or other mental impairment, does the Care Receiver require substantial supervision to maintain their health and safety?	
SENIOR is Raising a Child with a severe disability?	

CAREGIVER Screening Y/N (a Yes response = points)	Y/N
Caregiver has been hospitalized or has visited ER in the past 6 months?	
Caregiver has not had an annual check-up in the past 6 months?	
Caregiver has more than 2 limiting current health problems?	
Caregiver has chronic mental health issues?	
Caregiver household is multi-generational?	
Caregiver's income has been reduced as a result of caregiving?	
Caregiver's expenses have significantly increased as a result of caregiving?	
Caregiver's living arrangements create difficulty in providing care?	
Caregiver has no one to provide respite/relief?	
Caregiver has no one to call for help or assistance?	

Caregiver provides X hours of hands on care for Care Recipient per week:	CHECK ONE ONLY
Less than 10 hrs	
10 to 19 hrs	
20 to 29 hrs	
30 to 39 hrs	
40 to 49 hrs	
50 to 59 hrs	
60 + hrs	

Caregiver:	Never	Rarely	Sometimes	Frequently	Always
Is In Crisis					
Has a Care Receiver that requires constant supervision					
Feels that because of the time spent with Care Receiver, doesn't have time for self					
Feels stressed between providing care and trying to meet other responsibilities (work/family)					
Feels strained when around your relative					
Feels uncertain about what to do about relative					