

COMPASS – Comprehensive Assessment for Aging Network Community-Based Long Term Care Services

INTAKE INFORMATION

A. Person's Name:

B. Address:

C. Phone #: H: _____ C: _____ E-mail: _____

D. Date of Referral:

E. Referral Source (*Specify Name, Agency and Phone*):

F. Presenting Problem/Person's Concern(s):

G. Does the person know that a referral has been made? [] Yes [] No if no why not?

H. Intake Workers Name: _____ E-mail: _____

The client information contained in this assessment instrument is confidential and may be shared with others only as necessary to implement the client's care plan and comply with program requirements, including but not limited to monitoring, research and evaluation.

**NYSOFA 246 (04/14) CO M PASS - Comprehensive Assessment for Aging Network
Community Based Long Term Care Services**

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CASE IDENTIFICATION

Client Case
Assessment Date: Assessor Name:

Assessment Agency:

Reason for COMPASS Completion:
 Initial Assessment
 Reassessment

Next Assessment Date: _____

CLIENT INFORMATION

- A. Person's Name:
- B. Address (including zip code):
- C. E-mail:
- D. Telephone No.:
- E. Social Security No.:

F. Marital Status: (Check one)

- Married Widowed Domestic Partner or Significant Other Divorced
- Separated Single

G. Sex:

What was your sex at birth (on your original birth certificate)?

- Female Male

H. Transgender - Gender Identity or Expression?

Some people describe themselves as transgender when they experience a different gender identity from their sex at birth. For example, a person, born into a male body, but who feels female or lives as a woman. Do you consider yourself to be transgender?

- No;
- Yes, transgender male to female;
- Yes, transgender female to male;
- Yes, transgender, do not identify as male or female.
- Did not answer.

I. Birth Date (mm/dd/yyyy): _____ Age: _____

J. Race/Ethnicity Check one

- American Indian/Native Alaskan Asian Black, Non-Hispanic
- Native Hawaiian/Other Pacific Islander White (Alone) Hispanic Other Race
- 2 or More Races White, Not Hispanic Hispanic

K. Sexual Orientation

- Do you think of yourself as: Heterosexual or Straight Homosexual or Gay
 Lesbian Bisexual Not Sure
 Did Not Answer Other

- L. Creed: Christianity Islam Hinduism Buddhism Judaism Did Not Answer
 Other

M. National Origin: _____

N. Primary Language (Check all that apply)

	English	Spanish	Chinese	Russian	Italian	French\ Haitian Creole	Korean	Other
Speaks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Reads	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Understands orally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

- O. Client does not speak English as their primary language and has ONLY a limited ability to read, speak, write or understand English. Yes No

P. Living-Arrangement:

- Alone With Spouse Only With Spouse & others
 With Relatives (excludes spouse) With Non-Relative(s), Domestic Partner
 Others Not listed

Q. During the last 6 months have you experienced any of the following forms of abuse?

- Physical Abuse Active and Passive Neglect
 Sexual Abuse Self Neglect
 Emotional Abuse Domestic Violence
 Financial Exploitation Other (e.g. Abandonment)

Was this referred to:

- Adult Protective Services AAA
 Police Agency Other _____
 Domestic Violence Service Provider Not Referred

R. Emergency Contact: _____

Primary

Name:

Address:

Relationship:

Home Phone:

Cell Phone:

Secondary

Name:

Address:

Relationship:

Home Phone:

Cell Phone:

- S. a. Is the client frail? Yes No
- b. Is the client disabled? Yes No

II HOUSING STATUS

A. Type of Housing:

- multi-unit housing single family home other

B. Person (check): owns rents other Specify

C. Home Safety Checklist: (Check all that apply)

- Accumulated garbage
- Bad odors
- Carbon monoxide detectors not present/not working
- Doorway widths are inadequate
- Floors and stairways dirty and cluttered
- Loose scatter rugs present in one or more rooms
- No lights in the bathroom or in the hallway
- No handrails on the stairway
- No lamp or light switch within easy reach of the bed
- No locks on doors or not working
- No grab bar in tub or shower
- No rubber mats or non-slip decals in the tub or shower
- Smoke detectors not present/not working
- Stairs are not lit
- Stairways are not in good condition
- Telephone and appliance cords are strung across areas where people walk,
- Traffic lane from the bedroom to the bathroom is not clear of obstacles
- Other (specify)

D. Is neighborhood safety an issue? Yes (If Yes, Describe) No

Comments:

III HEALTH STATUS

A. Primary Physician: _____
 Clinic/HMO: _____
 Hospital: _____
 Other: _____

B. Indicate date of last visit to primary medical provider: Month _____ Year _____

C. Does the person have a self-declared chronic illness and/or disability? (Check all that apply)		
<input type="checkbox"/> alcoholism	<input type="checkbox"/> diarrhea	<input type="checkbox"/> Parkinson's
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> digestive problems*	<input type="checkbox"/> Pernicious anemia
<input type="checkbox"/> anorexia	<input type="checkbox"/> diverticulitis	<input type="checkbox"/> renal disease
<input type="checkbox"/> arthritis	<input type="checkbox"/> fractures (recent)	<input type="checkbox"/> respiratory problems
<input type="checkbox"/> cancer	<input type="checkbox"/> frequent falls	<input type="checkbox"/> shingles
<input type="checkbox"/> cellulitis	<input type="checkbox"/> gall bladder disease	<input type="checkbox"/> smelling impairment
<input type="checkbox"/> chronic obstructive pulmonary disease (COPD)	<input type="checkbox"/> hearing impairment	<input type="checkbox"/> speech problems
<input type="checkbox"/> chronic pain	<input type="checkbox"/> heart disease	<input type="checkbox"/> oxygen dependent
<input type="checkbox"/> colitis	<input type="checkbox"/> hiatal hernia	<input type="checkbox"/> paralysis
<input type="checkbox"/> colostomy	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> stroke
<input type="checkbox"/> congestive heart failure	<input type="checkbox"/> high cholesterol*	<input type="checkbox"/> swallowing difficulties
<input type="checkbox"/> constipation	<input checked="" type="checkbox"/> hyperglycemia	<input type="checkbox"/> taste impairment
<input type="checkbox"/> decubitus ulcers	<input type="checkbox"/> hypoglycemia	<input type="checkbox"/> traumatic brain injury
<input type="checkbox"/> dehydration	<input checked="" type="checkbox"/> incontinence	<input type="checkbox"/> tremors
<input type="checkbox"/> dental problems*	<input type="checkbox"/> legally blind	<input type="checkbox"/> ulcer
<input type="checkbox"/> developmental disabilities	<input type="checkbox"/> liver disease	<input type="checkbox"/> urinary Tract infection
<input type="checkbox"/> diabetes	<input type="checkbox"/> low blood pressure	<input type="checkbox"/> visual impairment
<input type="checkbox"/> dialysis	<input type="checkbox"/> osteoporosis	<input type="checkbox"/> other (Specify)

*May indicate need for assessment by nutritionist

D. Does the person have an assistive device? Yes (If yes, check all that apply) No

<input type="checkbox"/> Accessible vehicle	<input type="checkbox"/> Hearing Aid
<input type="checkbox"/> Bed rail	<input type="checkbox"/> Lift chair
<input type="checkbox"/> Cane	<input type="checkbox"/> Scooter
<input type="checkbox"/> Denture: <input type="checkbox"/> Full <input type="checkbox"/> Partial	<input type="checkbox"/> Walker
<input type="checkbox"/> Glasses	<input type="checkbox"/> Wheelchair\Transportable folding
	<input checked="" type="checkbox"/> Other

E. Does the person need an assistive device? Yes No (If yes, specify device)

F. Does the person and/or caregiver need training on the use of an assistive device?

Yes (If yes, describe training needs) No

G. Has the person been hospitalized in the last 6 months?

Yes (If yes, describe the reason for the recent hospitalization) Month: Year:

No

H. Has the person been taken to the emergency room within the last 6 months?

Yes (If yes, describe the reason for the most recent ER visit) Month: Year: No

I. Has a PRI and/or DMS-1 been completed in the past 6 months?

Yes (If Yes, describe the reason for, completion) No

____DMS-1 Score:

Completed by _____

(Name and Affiliation)

Date completed: Month: _____ Year: _____

____PRI Score:

Completed by: _____

(Name and Affiliation)

Date completed: Month: _____ Year: _____

Comments:

J. Alcohol Screening Test - The CAGE Questionnaire

Check all that apply

Have you ever felt you should cut down on your drinking?

Have people annoyed you by criticizing your drinking?

Have you ever felt bad or guilty about your drinking?

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)?

IV. NUTRITION

A. Person's height _____ Source: _____

B. Person's weight _____ Source: _____

C. Body Mass Index ___ calculated from height and weight as follows: weight in pounds x 703: Divide this number by height in Inches then divide by height in Inches again. Healthy older adults should have a BMI between 22 and 27. A BMI outside of this range may indicate the need for a referral to a dietitian.)

D. Are the person's refrigerator/freezer and cooking facilities adequate? Yes No (if no, describe)

E. Is the person able to open containers/cartons and cut up food? Yes No if no, describe

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F. Does the person have a physician prescribed modified therapeutic diet?

Yes (If yes, check all that apply)

Texture-Modified Calorie Controlled Diet Sodium Restricted

Fat Restricted High Calorie Renal

Other {Specify} _____

No (If No, Check all that apply)

Regular Special Diet (Check all//that apply)

Ethnic/Religious (specify) _____ Vegetarian

G. Does the person have a physician-diagnosed food allergy? Yes (If yes, describe) No

H. Does the person use nutritional supplements?

Yes (If yes specify who described and the supplement) No

I. Nutritional Risk Status

Check all that apply and circle the corresponding number at right

	Score
<input type="checkbox"/> Has an illness or conditions that made me change the kind and/or amount of food eat.	2
<input type="checkbox"/> Eats fewer than 2 meals per day.	3
<input type="checkbox"/> Eats few fruits or vegetables, or milk products.	2
<input type="checkbox"/> Has 3 or more drinks of beer, liquor, or wine almost every day.	2
<input type="checkbox"/> Has tooth or mouth problems that make it hard for me to eat.	2
<input type="checkbox"/> Does not always have enough money to buy the food I need.	4
<input type="checkbox"/> Eat alone most of the time.	1
<input type="checkbox"/> Take 3 or more different prescribed or over-the-counter drugs a day.	1
<input type="checkbox"/> Without wanting to, I lost or gained 10 or more pounds in the last 6 months.	2
<input type="checkbox"/> Not always physically able to shop, cook, and/or feed myself.	2

NSI Score: _____

A score of 6 or more indicates "High" nutrition risk. 3-5 Indicates "Moderate" nutrition risk, and 2 or less Indicates "Low" nutritional risk.

Conclusion: Based on the NSI score, this person is at check one:

High Risk Moderate Risk Low Risk

Comments:

V. PSYCHO-SOCIAL STATUS

A. Psycho-Social Condition

Does the person appear, demonstrate and/or report any of the following (check all that apply)?

- alert
- impaired decision making
- self-neglect
- cooperative
- lonely
- suicidal behavior
- dementia
- memory deficit
- worried or anxious
- depressed
- physical aggression
- other (specify)
- disruptive socially
- sleeping problems
- hallucinations
- suicidal thoughts
- hoarding
- verbal disruption

B. Evidence of substance abuse problems? Yes (if yes describe) No

C. Problem behavior reported? Yes (if yes describe) No

D. Diagnosed mental health problems? Yes (if yes describe) No

E. History of mental health treatment? Yes (if yes describe) No

F. Does it appear that a mental health evaluation is needed?

Yes (If Yes, note Referral Plan In the Care Plan) No

Comments:

VI. PRESCRIBED

A. MEDICATIONS.

Name	Dose/Frequency	Reason Taken

B. Primary Pharmacy Name Phone

C. Does the person have any problems taking medications?

D. Adverse reactions/allergies/sensitivities? Yes, if Yes. Describe No

E. Cost of medication Yes, if Yes. Describe No

F. Obtaining medications Yes, if Yes. Describe No

G. Other (Describe)

**VII. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)
STATUS/UNMET NEED**

Activity Status: **1=Totally Able**
(Use for Sec. VII & VIII) **2=Requires intermittent supervision and/or minimal assistance.**
 3=Requires continual help with all or most of this task
 4=Person does not participate; another person performs all aspects of this task.

Activity: What can person do?	Enter Person's Activity Status				Comments: Describe limitations, parts of tasks to be done and responsibilities of informal supports and formal Services.
	Is Need Met*	Activity Status	Informal Supports	Formal Services	
A. Housework/cleaning					
B. Shopping					
C. Laundry					
D. Use transportation					
E. Prepare & cook meals					
F. Handle Personal business/finances					
G. Use Telephone					
H. Self-admin of medications					

*Is Need Met Currently (at time of Assessment)?

ARE CHANGES IN IADL CAPACITY EXPECTED IN THE NEXT 6 MONTHS? Yes (If Yes, describe) No

**VIII. ACTIVITIES OF DAILY LIVING (ADLs)
STATUS/UNMET NEED**

Activity: *What can person do?* Enter Person's Activity Status *Check if assistance is/will be provided by*

	Is Need Met*	Activity Status	Informal Supports	Formal Services	Comments <i>Describe limitations, parts of tasks to be done and responsibilities of informal supports and formal services.</i>
A. Bathing 1. Requires no supervision or assistance. May use adaptive equipment. 2. Requires intermittent checking and observing/minimal assistance at times 3. Requires continual help. 4. Person does not participate.					
B. Personal Hygiene 1. Requires no supervision or assistance 2. Requires intermittent supervision and/or minimal assistance. 3. Requires continual help with all or most of personal grooming. 4. Person does not participate; another person performs all aspects of personal hygiene					
C. Dressing 1. Needs no supervision or assistance. 2. Needs intermittent supervision/minimal assistance at times. 3. Requires continual help and/or physical assistance. 4. Person does not participate, is dressed by another, or bed gown is generally worn due to condition of person.					
D. Mobility 1. Walks with no supervision or assistance. May use adaptive equipment. 2. Walks with intermittent supervision. May require human assistance at times. 3. Walks with constant supervision and/or physical assistance. 4. Wheels with no supervision or assistance, except for difficult maneuvers, or is wheeled, chairfast or bedfast. Relies on someone else to move about, if at all.					
E. Transfer 1. Requires no supervision or assistance. May use adaptive equipment. 2. Requires intermittent supervision. May require human assistance at times. 3. Requires constant supervision and/or physical assistance. 4. Requires lifting equipment and at least one person to provide constant supervision and/or physically lift, or cannot and is not taken out of bed.					
F. Toileting 1. Requires no supervision or physical assistance. May require special equipment, such as raised toilet or grab bars. 2. Requires intermittent supervision and/or minimal assistance. 3. Continent of bowel and bladder. Requires constant supervision and/or physical assistance. 4. Incontinent of bowel and/or bladder.					
G. Eating 1. Requires no supervision or assistance. 2. Requires intermittent supervision and/or minimal physical assistance. 3. Requires continual help and/or physical assistance. 4. Person does not manually participate. Totally fed by hand, a tube or parental feeding for primary intake of food,					

*Is Need Met Currently (at time of Assessment)?

ARE CHANGES IN ADL CAPACITY EXPECTED IN THE NEXT 6 MONTHS? Yes (If Yes, describe) No

IX. SERVICES CLIENT CURRENTLY IS RECEIVING

A. What formal service(s) does the person currently receive? *(Check all that apply)*

none utilized

Provider Information

adult day health care

assisted transportation

caregiver support

case management

community-based food program

consumer directed in-home services

congregate meals

equipment/supplies

friendly visitor/telephone reassurance

health promotion

health insurance counseling

home health aide

home delivered meals

hospice

housing assistance

legal services

mental health services

nutrition counseling

occupational therapy

outreach

personal care level 1

personal care level 2

personal emergency response system (PERS)

physical therapy

protective services

respite

respiratory therapy

senior center

senior companions

services for the blind

shopping

skilled nursing

social adult day care

speech therapy

transportation

other (specify)_____

X. INFORMAL SUPPORT STATUS

- A. Does the person have family, friends and/or neighbors who help or could help with care?
 Yes No (If No, skip to question C of this section)

Primary Informal Support

1. Name:

Address:

Relationship:

Home Phone:

Work Phone:

Cell Phone:

E-mail:

Involvement: (Type of help/frequency)

1. a. Does the consumer appear to have a good relationship with this informal support?
 Yes No (Explain)
1. b. Would the consumer accept help, or more help, from this informal support in order to remain at home and/or maintain independence? (Check one)
 willing to accept help unwilling to accept any help
1. c. Are there any factors that might limit this informal support's involvement? (Check all that apply)
 job finances family responsibilities physical burden transportation
 emotional burden health problems reliability living distance
1. d. Would this informal support be considered the caregiver? (Definition of caregiver can be found on page 39 of the instructions.) Yes No
1. e. Does the caregiver identify the need for **respite**? Yes No
 If yes, when? Morning Afternoon
 Evening Overnight
 Weekend Other
1. f. Which of these services could be provided as respite for the caregiver?
 Adult Day Services Personal Care Level 1 Personal Care Level 2
 In Home Contact & Support (Paid Supervision)
1. g. Would the caregiver like to receive information about other caregiver services?
 Yes No

Secondary Informal Support:

2. Name:

Address:

Relationship:

Home Phone:

Work Phone:

Cell Phone:

E-mail:

Involvement: (Type of help/frequency)

2. a. Does the consumer appear to have a good relationship with this informal support? Yes
 No (Explain)

2. b. Would the consumer accept help, or more help, from this informal support in order to remain at home and/or maintain independence? (Check one)

willing to accept help unwilling to accept any help

2. c. Are there any factors that might limit this informal support's involvement? (Check all that apply)

job finances family responsibilities physical burden transportation

emotional burden health problems reliability living distance

2. d. Would this informal support be considered the caregiver? (Definition of caregiver can be found on page 39 of the instructions.) Yes No

2. e. Does the caregiver identify the need for respite? Yes No

If yes, when? Morning Afternoon

Evening Overnight

Weekend Other

2. f. Which of these services could be provided as respite for the caregiver?

Adult Day Services Personal Care Level 1 Personal Care Level 2

In Home Contact & Support (Paid Supervision)

2.g. Would the caregiver like to receive information about other caregiver services?

Yes No

B. Can other Informal supports) provide temporary care to relieve the caregiver(s)?

Yes (if yes, describe) No

C. Does the person have any community, neighborhood or religious affiliations that could provide assistance? Yes (If Yes, describe who might be available, when they might be available and what they might be willing to do)

Comments:

XI. MONTHLY INCOME

A.

		Monthly Income			
		A. Individual Being Assessed	B. Person's Spouse	C. Other Family/ Household Income	D. Total Family/ Household Income
1.	Social Security (net)				
2.	Supplemental Security Income: (SSI)				
3.	Personal Retirement Income				
4.	Interest				
5.	Dividends				
6.	Salary/Wages				
7.	Other				
	Total:				

B. Number of people in household _____

C. Is client a veteran? _____

D. Check if person will provide no financial information (Describe)

XII. BENEFITS/ENTITLEMENTS

Benefit Status Code must be noted:	A. Has the benefit/entitlement
	B. Does not have the benefit/entitlement
	C. May be eligible and is willing to pursue benefit/entitlement
	D. Refuses to provide Information

Benefit	Benefit Status Code	Comments
<i>Income Related Benefits</i>		
Social Security		
SSI*		
Railroad retirement		
SSD		
Veteran's Benefits (Specify)		
Other (Specify)		
<i>Entitlements</i>		
Medicaid Number		
Food Stamps (SNAP)		
Public Assistance		
Other (Specify)		
<i>Health Related Benefits</i>		
Medicare Number		
QMB		
SLIMB		
EPIC		
Medicare Part D		
Medigap Insurance/HMO (Specify)		
Long Term Care Insurance (Specify)		
Other Health Insurance (Specify)		
<i>Housing Related Benefits</i>		
SCRIE		
Section 8		
IT214		
Veteran Tax Exemption		
Reverse Mortgage		
Real Property Tax Exemption (STAR)		
HEAP		
Other		

*Persons receiving SSI is categorically eligible for Medicaid and should have a Medicaid card.

XIII. CARE PLAN

Person's Name: _____

Date: _____

Address: _____

Prepared by: _____

Person's Phone: _____

A. Is the person self-directing/able to direct care? Yes No *(If No, who will provide direction?)*

B. Problems to be addressed?	Goals	Care Plan Objectives	Proposed Time Frame

C. What are the person's preferences regarding provision of services?

D. Types of services to be provided	How Much? When? Frequency	Start Date	Projected End Date	Provided: Informal/ Formal	Provider

E. Problems to be referred	Referred to:	(Reminders - some possible referrals)
		Hospital, Nursing Home, Adult Home, Health Assessment, Long Term Care Home Health Care Program, Personal Care Program, Mental Health Assessment, Housing Assessment, Certified Home Health Agency, Licensed Home Care Services Agency, Protective Services for Adults, Other

F. Information/special Instructions that have direct bearing on Implementation of the care plan:

G. Has person been placed on waiting list for any service need? Yes (If Yes List) No

Service

Provider

Date Placed on List

H. Plan has been discussed and accepted by client and/or Informal supports? Yes No (If No, explain)

I. Plan approved by: _____ Date: / / Phone: _____

Signature and Title

SERVICE/CARE PLAN TERMINATION

A. What is being terminated? Services(s) Care Plan
If Service, Specify which one(s)

B. Termination Date:

C. Reason for termination: (Check all that apply)

- None (Reason Unknown)
- Goal Met: (Specify) _____
- Client Request
- Client Moved
- Hospitalization
- Nursing Facility
- Assisting Living
- Death
- Other: (specify) _____

D. Service of Care Plan Related Client Outcome(s) Statements: _____

E. Terminated by: _____

Signature Title

Date: Work Phone: Cell Phone: E-mail