

MINIMUM DATA SET

(April 2014)

Listed Below Are The Minimum/Basic Data Elements To Be Collected For The Following Services:

Personal Care Levels 1 & 2, Case Management, Home Health Aide Services, Home Delivered Meals, Consumer Directed In-Home and Social Adult Day Care

INTAKE INFORMATION

Intake Worker's Name: Date of Referral: Referral Source:

Presenting Problem and/or Client's Concerns:

Does the client know the referral is being made? If not, why?

CASE IDENTIFICATION

Assessor Name:

Client Case Number: Agency Name:

Reason for Completion: Assessment, Reassessment, Event Based.

CLIENT INFORMATION

Client Name:

Social Security Number:

Client's Address with Zip Code, Telephone Number, Date of Birth: Age, Sex:

Marital Status: Married, Widowed, Divorced, Separated, Single

Sex: Female, Male

Transgender: Male to Female, Female to Male

Birth Date:

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

Sexual Orientation: Heterosexual or Straight, Homosexual or Gay, Lesbian, Bisexual, Other

Creed: Christianity, Islam, Hinduism, Buddhism, Judaism, Other

National Origin:

Language: Primary Language, Speaks, Reads, Understands English, Spanish, Chinese, Russian, Italian, French\Haitian Creole, Korean, Other

Living Arrangement: Alone, With Spouse Only , With Spouse & Others, With Relatives (Excludes Spouse), With Non- Relatives, Domestic Partner, Others

EMERGENCY CONTACT

Name, Address, Phone (home/work), Relationship. Specify if more than one Emergency Contact.

INFORMAL SUPPORT STATUS

Is there a member of the client's family, a friend or neighbor who helps with care? If yes, indicate Name, Address, Phone, and Relationship. Specify if more than one Informal Caregiver.

How often does -this person help the client? Be as 'specific as possible.

Specify if more than one Informal Caregiver is providing help. Describe help the informal Caregiver provides: Tasks, Supervision, Social/Emotional Support, Transportation, Other (specify).

Does the client appear to have a good relationship with his/her informal caregivers?

Note any factors that might limit caregiver involvement: Job, Finances, Family Responsibilities, Physical Burden, Emotional Burden, Health Problems, Reliability, other (specify).

To what extent would client accept help from family in order to remain at home and/or independent- Definitely yes but only short term, Possibly but uncertain, Never, Other (specify).

Evaluation of informal support system: Adequate, Could expand if, needed, Adequate could not expand, Inadequate/Limited, Temporarily Unavailable, Other (specify).

Is caregiver relief needed? If yes, explain.

When is relief - for the caregiver needed: Morning, Afternoon, Evening, Overnight, Weekend, Other (specify).

Can other informal support(s) provide temporary care to relieve caregiver? If yes, explain.

Does the client have any community/neighborhood/religious affiliations that could provide assistance? If yes, explain.

Would the person providing "informal supports" be considered by definition a care giver?

SERVICES CLIENT IS CURRENTLY RECEIVING

What Services Does the Client Currently Receive: None utilized, Adult Day Health Care,, Caregiver Support, Case Management, Community-based Food Program, consumer directed in-home services, Congregate Meals, Equipment/Supplies, Escort, Friendly Visitor/Telephone Reassurance, health promotion , Home Delivered Meals, Home Health Aide, Health Insurance Counseling, Homemaker/Personal Care Services, Hospice, Housing Assistance, Legal Services, PERS, Mental Health Services, Nutrition Counseling, Occupational Therapy, Outreach, 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).

Provider Name, Service, Address, Telephone, Contact Person

IADL STATUS/UNMET NEED

Status must be noted: Totally Able, Requires intermittent supervision and/or minimal assistance,

Requires continual help with all or most of this task and Person does not participate; another person performs all aspects of this task.

Activity	Met	Status	Comments
Housework/cleaning	Y/N		
Shopping, Laundry	Y/N		
Use transportation	Y/N		
Prepare & cook meals	Y/N		
Self-admin of medications	Y/N		
Handle Personal business/finances	Y/N		
Use Telephone	Y/N		

ADL STATUS/UNMET NEED

Status must be noted: Totally Able, Needs Some Assistance, Needs Maximum Assistance, and Unwilling to Perform.

Activity	Met	Status	Comments
Personal Hygiene	Y/N		
Dressing	Y/N		
Mobility	Y/N		
Transfer	Y/N		
Toileting	Y/N		
Bathing	Y/N		
Eating	Y/N		

COGNITIVE STATUS

Psycho/Social Condition: Alert, Cooperative, Dementia, Depressed, Diagnosed Mental Health Problem, Disruptive Socially, Evidence of Substance Abuse, Hallucinations, hoarding, impaired Decision Making, Memory Deficit, Physical Aggression, Problem Behavior Reported, History of Mental Health Treatment, Evidence of Substance Abuse Problems, Verbal Disruption, Worried or Anxious, Suicidal Thoughts, Sleeping Problems, Appears Lonely, Other (specify).

Does it appear that a Mental Health Evaluation is needed?

HEALTH STATUS

Primary Physician/Clinic/Hospital: Name, Address and Phone Date of last visit to Primary Medical Provider:

Does the client have a Chronic Illness and/or Self-Declared

Disability: Alcoholism, Alzheimer, Anemia, Anorexia, Arthritis, Cancer, Chronic Constipation, Chronic Diarrhea, Colitis, Colostomy, Congestive Heart Failure, Dehydration, Dental Problems, Diabetes, Digestive Problems, Diverticulitis, Gall Bladder Disease, Hearing Impairment, Heart Disease, Hiatal Hernia, High Blood Pressure, Hypoglycemia, Liver Disease, Low Blood Pressure, Osteoporosis, Parkinson's, Recent Fractures, Renal Disease, Respiratory Problems, Smelling Impairment, Speech Problems, Stroke, Swallowing Difficulties, Taste Impairment, Ulcer, Urinary Tract Infection, Visual Impairment, Other (specify).

Does the client have an assistive device: Cane, Dentures, Glasses, Hearing Aid, Walker, Wheelchair, other (specify).

If yes, does the client/caregiver need training on use?

Has the client been hospitalized within the last 6 months?

If yes, indicate reason for admission and hospital discharge date.

Has the client been brought to the emergency room within the last 6 months? If yes, indicate reason for most recent ER visit and date.

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

If yes, indicate date of most recent completion, by whom and score.

PRESCRIBED AND OVER-THE-COUNTER MEDICATIONS CURRENTLY TAKEN Name of Medication, Dose/Frequency and Reason Taken.

Does the client state any problems with medications) - Adverse

Reactions/Allergies, Cost of Medication, Obtaining Medications, Other (specify).

HOUSING STATUS

Type of Housing: Single Family Unit or Multi-unit Dwelling Does the Client: Rent, Own, Other (specify)

Home Safety Checklist: Smoke/CO detectors are not present/working,

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

Is Neighborhood Safety an issue?

NUTRITION

Reported Height: Feet /Inches. Reported Weight: Pounds. Body Mass Index:

Are the client's refrigerator/freezer and cooking facilities adequate?

Is the client able to open containers/cartons and to cut-up food? Does the client use nutritional supplements?

Does the client have a physician diagnosed food allergy?

Does the client have a physician prescribed modified/therapeutic diet?

Nutritional Risk Status (NSI)

Client has illness/condition that changes kind/amount of food eaten, Eats fewer than 2 meals/day, Eats few fruits or vegetables, or milk products, Has 3+ drinks of beer/wine/liquor almost every day, Has tooth/mouth problems making it hard to eat, Does not always have enough money to buy food needed, Eats alone most of the time, Takes 3+ prescribed/over-the-counter drugs/day, Lost or gained 10 pounds in last 6 months, Not always able to physically shop, cook and/or feed self.

Score by adding the numbers of those factors that were answered Y.

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

MONTHLY INCOME

Monthly Income: SS (net), SSI, Pension/Retirement Income, Interest, Dividends, Salary/Wages, Other (specify).

ENTITLEMENTS

Benefit Status Code must be noted: Has the Benefit/Entitlement, Does not have the Benefit/Entitlement, or May be Eligible and is willing to pursue the Benefit/Entitlement.

EPIC, Food Stamps(SNAP), Health Insurance, HEAP, IT-214, Lifeline/PERS, Long Term Care Insurance, Medicaid, Medicare, Medicare Part D, Medigap Insurance/HMO, Private Health Insurance, Public Assistance, QMB, Railroad Retirement, Real Property Tax Exemption (STAR), Reverse Mortgage, Section 8 Housing, SLIMB, Social Security, SSD, SSI, VA Benefits, Veteran Tax Exemption, WRAP

Does the client need information and/or counseling on benefits and entitlement programs?

CARE PLAN

Is the client self-directing/able to direct home care staff? Indicate the client's preferences regarding provision of services

Goals:

Care Plan Objectives:

Proposed Time Frame to Achieve Stated Goals and Objectives:

Provider name, provider ID, formal/informal, service type,
Start

Date, End Date

Frequency: Number of Hours/Day

Frequency Period: Daily, Weekly, Bi-weekly, Monthly, Bi-monthly, Yearly, Other (specify).

Referrals made for service:

Information/Special Instructions

Type of Diet: Regular

Special Diet: Vegetarian, Ethnic, Religious (indicate type), Other (specify)

Modified/Therapeutic: Texture Modified, Calorie Controlled Diet, Sodium Restricted, Fat Restricted, High Calorie, Renal, Other (specify)

Has the client been placed on a waiting list for any service need? If yes, specify date. Specify service

Plan has been discussed and accepted by client and/or informal supports.

Plan Approved by:

Signature and Title, Date, Phone

Service Termination Date:

Client Outcome Statements: (completed upon service termination) Plan Terminated by:

Signature and Title, Date, Phone