

NEW YORK STATE OFFICE FOR THE AGING

2 Empire State Plaza, Albany, NY 12223-1251

Andrew M. Cuomo, Governor

Greg Olsen, Acting Director

An Equal Opportunity Employer

PROGRAM INSTRUCTION

Number: 13-PI-07

Supersedes: 97-PI-01 and 12-PI-07

Expiration Date:

DATE: March 18, 2013

TO: Area Agency on Aging Directors

SUBJECT: Revised Minimum Data Set and Comprehensive Assessment for Aging Network Community-Based Long Term Care Services (COMPASS) Forms and Instructions

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ACTION REQUESTED: Implementation of NYSOFA's revised Minimum Data Set (MDS) and compliance with reporting requirements pursuant to changes in law and regulations.

RESPONSE DUE DATE: The revisions to the COMPASS and client file specifications will be available for the April 2013 - March 2014 program year. We will begin collecting this information beginning April 1, 2013. However we understand full implementation will not take place until training has been provided. NYSOFA will begin reviewing collected data and perform edit checks for the additional information in the July – September 2013 quarter.

PURPOSE: To transmit revisions to the COMPASS and client file specifications for use in client data reporting.

BACKGROUND: NYSOFA has been in the process of adding questions to the COMPASS and other systems to reflect changes in law and regulations and ongoing program operations. These additional questions focus on the following areas:

- **Social Security Number:** As part of the Systems Integration (SI) Grant, Part A, ACL/AoA has requested that we provide the last four digits of the client's social security number. This will enable them to review our data against data collected by the Centers for Medicare and Medicaid Services (CMS) to better measure the

impact of long term services and supports. We understand that not all systems collect this information, so we will be working with the AAAs during the SI grant period to determine how this may be accommodated.

- **Underserved populations:** The new reporting requirements pertaining to this category are mandated by Chapter 547 of the Laws of 2011 (A.880/S.1303). The groups\elements covered by the law and not presently included in the Minimum Data Set, COMPASS, and reporting systems are national origin, creed, sexual orientation, and gender identity or expression. NYSOFA has added these elements.
- **Limited English Proficiency (LEP):** In order to assess the aging networks' efforts in serving those persons for whom limited English proficiency creates a barrier to receiving needed services, data elements pertaining to the number of individuals served who are LEP and who speak one of six languages needs to be collected. This data is needed to assess compliance with Governor Cuomo's Executive Order #26, Statewide Language Access Policy, and compliance with Title VI of the Civil Rights Act and Federal Executive Order 13166. NYSOFA has added a question on Limited English Proficiency (LEP).
- **Elder Abuse/Domestic Violence:** NYSOFA has added data elements in this category as part of a statewide initiative involving a number of State and private sector organizations. The purpose is to identify persons suffering elder abuse or domestic violence and the agencies these persons are referred to for assistance. The definitions for these areas of abuse are taken from Social Services Law § 473 and NY Codes, Rules and Regulations, 18 NYCRR § 457.1.
- **Informal Supports:** This section of the Assessment collects a great deal of information on the persons and roles they play in providing informal supports which enable an older person to remain in their home. Collecting this information will help NYSOFA in meeting the goals and objectives of the Systems Integration Grant as well as other initiatives in which the role of caregivers is becoming increasingly important. We are adding a question that will ask if the person providing informal supports can be considered a caregiver. This will enable us to gauge the extent of caregiver support in these programs.
- **CAGE Questionnaire, A Screening Test for Alcohol Dependence:** There have been requests from the network for tools to assist case managers in better screening clients. The CAGE questionnaire, the name of which is an acronym of the key words in the questions, (cut, annoyed, guilty, eye-opener) is a widely used method of screening for alcoholism. The test is a straightforward, 4 question alcohol screening tool, used by many professionals in the alcohol

addiction field that simplifies the process of identifying those with possible alcohol problems. Individuals scoring 2 or more on the CAGE Questionnaire should be referred to an Alcohol Specialist.

- Added additional codes as requested by AAAs for sections on chronic illness, assistive devices and psycho-social statuses.

Sexual orientation and gender identity or expression questions: NYSOFA has been working with the Services & Advocacy for Gay, Lesbian, Bisexual & Transgender Elders (SAGE) organization, the software vendors, and several AAAs on implementing these changes to the MDS, COMPASS form, and file specifications.

NYSOFA also has been working with SAGE to develop a webinar and provide support for the network as we begin the process of implementing these questions and reporting requirements.

For all of the changes described in this Program Instruction, NYSOFA has been working with the vendors to make the changes to their systems and update their versions of the COMPASS assessment tool. NYSOFA has requested that the vendors make the revised assessment form available to their users simultaneously with the release of this Program Instruction. NYSOFA will begin reviewing collected data in the July – September quarter, and will begin performing edit checks for this information during that quarter.

The revised COMPASS form and instructions are included with this Program Instruction, as well as the revised Minimum Data Set, Client Data Specifications, Client File Codes, and a Sample Congregate Services intake form. Please note that the COMPASS is provided as an example of what the assessment tool may look like. The tool provided by your vendor may vary, but must include all the Minimum Data Set (MDS) elements, as well as other data fields added as part of the annual system updates. Key changes are outlined, below:

Key Changes

Social Security Number, Last four digits to be reported

Creed

- 1=Christianity
- 2=Islam
- 3=Hinduism
- 4=Buddhism
- 5=Judaism
- 6=Did Not Answer
- 7=Other

National Origin, countries are listed in Att. B, Sec. H

Sexual Orientation

- 1=Heterosexual or Straight
- 2=Homosexual or Gay
- 3=Lesbian
- 4=Bisexual
- 5=Not Sure
- 6=Did Not Answer
- 7=Other

Transgender - Gender Identity or Expression

- 1=Male to Female
- 2=Female to Male
- 3=Transgender, did not identify as male or female
- 4=No
- 5=Did not answer

Living Status, added 6=Others

Marital Status, added 3=Domestic Partner or Significant Other

Client Characteristics

Added: 952 - HIV/AIDS and 944 - Hoarding

Primary Language for LEP clients, added the six most common languages

- 945 - Spanish
- 946 - Chinese
- 947 - Russian
- 948 - Italian
- 949 - French\Haitian Creole
- 950 - Korean
- 951 - Other

Elder Abuse types and agencies referred to:

- 01=Physical Abuse
- 02=Sexual Abuse
- 03=Emotional Abuse
- 04=Financial Exploitation
- 05=Active and Passive Neglect

06=Self Neglect
07=Domestic Violence
00=Other (e.g. Abandonment)

01=Adult Protective Services
02=Police Agency
03=Domestic Violence Service Provider
04=AAA
05=Other
06=Not Referred

Would person be considered the caregiver, Yes/No

Alcohol Screening Test - The CAGE Questionnaire

Have you ever felt you should cut down on your drinking? Yes/No

Have people annoyed you by criticizing your drinking? Yes/No

Have you ever felt bad or guilty about your drinking? Yes/No

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)? Yes/No

Attachments Included:

Att. 1 - Reporting Guide CAARS and Client Data 2013

Att. 2 - CAARS 2013 Quarterly Report Forms

Att. 3 - COMPASS Form 2013.doc

Att. 4 - COMPASS Instructions 2013.doc

Att. 5 - Minimum Data Set (MDS)

Att. A - Client Data Specifications 2013.xls - Provides description of the allowable file layout

Att. B - Client File Codes 2013.doc - Provides codes to be used in data reporting

Att. D - Sample Congregate Services Intake Form.doc (Race\Ethnic Additions)

Att. K - CAARS Client Reports 2013

Att. L - Examples of Case Managed and Non Case Managed Clients

PROGRAMS AFFECTED:

- | | | | | |
|---|---|---|---|---|
| <input checked="" type="checkbox"/> Title III-D | <input checked="" type="checkbox"/> Title III-E | <input checked="" type="checkbox"/> Title III-B | <input checked="" type="checkbox"/> Title III-C-1 | <input checked="" type="checkbox"/> Title III-C-2 |
| <input checked="" type="checkbox"/> EISEP | <input checked="" type="checkbox"/> NSIP | <input checked="" type="checkbox"/> CSE | <input checked="" type="checkbox"/> SNAP | <input type="checkbox"/> Energy |
| <input type="checkbox"/> Other: | | <input type="checkbox"/> Title V | <input type="checkbox"/> HIICAP | <input type="checkbox"/> LTCOP |

CONTACT PERSON: Bob Miller

TELEPHONE: (518) 473-1947

E-mail: bob.miller@ofa.state.ny.us

CAARS Data Entry Tool Instructions

Accessing the tool requires the following equipment and software:

- A computer with access to the Internet
- Internet Explorer 7.0 or later

Multiple users – The system was designed so that more than one person from an AAA can login and input data at the same time.

However, multiple users should NOT work on the same page at the same time. Doing so will likely lead to lost data and create re-work for your agency.

Every time the page is saved by one user, it will overwrite the changes made by others working on the same page.

To avoid this potential problem, coordinate with others in your AAA working on the quarterly report forms. There is no conflict if multiple users are working on different pages. The tool treats each page as a separate document and will only save changes to that page.

General Instructions for Submission\Revision

1. Login and Select the Quarter

To access the tool, we recommend using Internet Explorer ver. 7 or greater. Go to <http://reporting.aging.ny.gov>. This site uses a User Name and Password like that used for the AAARIN web site. If you do not have a User Name and password your Director can request one through your ASR

- Once on the NYSOFA Budgeting and Reporting Systems, Main Menu, you can select CAARS Quarterly on the left.
- Once you've made your selection a dialog window will appear in the center of the screen.
- The CAARS Quarterly Main Menu page will open.
- From this page you have three choices: review Reference Material, do Data Entry or use the Tools section to check for errors:

2. Enter Data and Navigate through the Pages

- From the Main Menu, select a page to begin
- Fill in the data fields on each page, note you need to open and save each page even if no data was entered.
- SAVE CHANGES FREQUENTLY
- If you enter data and save, but do not see the data you entered, click on View and Refresh or View and Reload.
- Navigate to other pages and the Main Menu using the links at the top of the page.

3. Submit Forms

From the Main Menu, you can check for errors by individual page or for all pages

- Clicking on the "Submit" button will show a notification on the screen that your report has been submitted.
- An e-mail will be sent to the e-mail address entered on page one of the report saying that the report has been submitted.

4. Print Forms

Click on "Print This Page" (a selection on the toolbar). A separate window (a PDF file) of the page will open. Users can save or print this PDF file. Once you close out of the PDF file, the original screen will still be up

5. Revisions\Correction\Extensions

A. CAARS

Once your forms are submitted, your data is locked from editing. To unlock the forms, send an e-mail to CAARS, caarsreports@ofa.state.ny.us. The e-mail will respond to the same address noted on the submitted CAARS form. If another person needs to be notified, just add their e-mail address to the request.

You will receive an e-mail reply notifying you when the forms have been unlocked. When the forms are unlocked, you can make your correction(s) and submit the forms again. If you are revising several quarters, it is important to do the revisions in sequence. For example, submit 1st quarter, then 2nd, etc.

Reports/Revisions are due according to the schedule below. Note that when the due date falls on a weekend or holiday, the due date is moved to the next working day.

B. Client Files

Client data is updated with each submission so corrections are made to the following quarter.

C. Extensions

If the AAA is unable to meet the reporting due date, an extension can be requested. To make a request send an e-mail for CAARS Reporting to caarsdata@ofa.state.ny.us and for client files to clientdata@ofa.state.ny.us. The subject should say Extension Request. In the body of the e-mail explain why the request is being made, for example a key staff person is temporarily unavailable and when the report will be submitted. If the request extends beyond one week you will need to send an update each week describing progress being made in being able to submit.

Quarter Reported	Reports Due	First Late Notice sent Via E-mail	Letter sent to AAA Dir. & County Exec.
April – June	July 22, 2013	July 29, 2013	Aug. 5, 2013
July – September	Oct. 21, 2013	Oct. 28, 2013	Nov. 5, 2013
October – December	Jan. 22, 2014	Jan. 28, 2014	Feb. 4, 2014
January – March	Apr. 24, 2014	Apr. 31, 2014	May 6, 2016

Due Dates

See Schedule above.

Late Notices

Late notices will be sent via e-mail according to the above schedule. These reminders will be followed by a letter sent 10 business days following the due date

with copies sent to Chief Executive Officer or Chairman of the Governing Board, Aging Services Representative, Aging Services Area Supervisor, Senior Accountant or Grants Management Budget Specialist 2 and the Deputy Director Aging Network Operations. **Note: this will result in NYSOFA withholding funding reimbursements until the CAARS\Client data is received in the prescribed format. If you have reasons that would mitigate or explain why your AAA is unable to meet this deadline, please advise us via e-mail. If you receive an E-mail late notice in error, please reply to the e-mail immediately so that reporting staff can follow-up. This ensures that you will not receive a late letter in error.**

View Reports

The standard CAARS reports can be viewed by going to <http://www.boedmz.ofa.state.ny.us/infoviewapp/logon.aspx>. This system uses the same username and password as noted above. A list of CAARS\Client reports can be found in Attachment K.

Section I - Area Agency Quarterly Report - NYSOFA #358

Overview

- These instructions incorporate all of the CAARS reporting requirements effective April 1, 2013.
- Periods Covered: April 1, 2013 – June 30, 2013; July 1, 2013 – September 30, 2013; October 1, 2013 – December 31, 2013 and January 1, 2014 - March 31, 2014 (The CAARS system accumulates data covering the State Fiscal Year).
- Cumulative data requested is from April 1, 2013.
- These instructions have been designed to follow the layout of the reporting forms.
- Complete all appropriate questions. Use estimates until final data is available.
- For all financial questions, **round to the nearest dollar. (Round up all Non-Federal, Non-State Share and Match amounts).**
- Complete Parts I A, B; II, and III each quarter. For Part I, question C. Staffing is only reported for the first quarter. Questions D. Provider Profile and E. Focal Points/Senior occurs just once a year with the final SFY quarterly report (i.e., the report ending March 31st).
- Comments may be sent as an e-mail attachment to the CAARS e-mail address, caarsreports@ofa.state.ny.us Comments must be labeled with AAA name, period covered, and contact person, if applicable.
- Contact Information:

NYS Office for the Aging
2 Empire State Plaza
Albany, NY 12223-1251

Bob Miller (518) 473-1947
Fax (518) 473-5177

By e-mail at: caarsreports@ofa.state.ny.us or clientdata@ofa.state.ny.us

Part I - General

A. Period Covered:

Information requested is completed by system.

B. Identification:

1. System will complete.
2. System will complete.
3. Enter name of person to be contacted for corrections (contact person).
4. Title of person (contact person) completing this report.
5. Area code, telephone number and e-mail address of contact person named above.
6. Area Agency on Aging director's review checkbox (*must be checked*).

C. Staffing

Area Agency Staffing: Develop the staffing profile of your agency as of June 30, 2012 for filled positions only. Enter the total number of full time equivalents (FTEs) and the total number of minority FTEs. Line 5, Total AAA Staff includes both paid staff and volunteers. The numbers reported should be consistent with those reported for June 30, 2011. For personnel classifications definitions, refer to Section VII, Glossary of Terms.

Note: *Full time equivalents (FTEs) should be based on local definition of what constitutes a full time employee. As an additional point of clarification, information systems activities should be included under "administration."*

When entering data on the Volunteer line(s), please do not enter the total number of volunteers. Enter the number of FTEs that would result when volunteer hours are aggregated. An estimate may be made by supervisors familiar with volunteer work activity for the year. AAAs are not expected to implement additional work requirements or record keeping to estimate volunteer FTEs. For Subcontractor volunteers, if possible provide your best estimate of the FTEs used by the subcontractor in providing the contracted services.

D. Provider Profile (Submit with January 1st - March 31st quarter.)

- a. Total number of Subcontractors providing services under a formal contractual agreement with the AAA.
- b. Total number of Subcontractors providing services to clients who live in rural areas.
- c. Total number of Minority Subcontractors providing services.

E. Focal Points/Senior Centers* (Submit with January 1st - March 31st quarter)

- a. On line 1, enter number of senior centers in the planning and service area.
- b. Of the total on line 1, enter on line 2 how many received Title III funds during the fiscal year.
- c. Of the total on line 1, enter on line 3 how many are designated as Focal Points. **
- d. On line 4, enter the total number of Focal Points operating in the planning and service area.

*Name & address of Centers/Focal Points are included in the Plan Roster.

**Focal Points: A place or mobile unit in a community or neighborhood designated by the area agency for the collocation and coordination of services.

Part II - Program Information (Complete Each Quarter)

A. EISEP Other Services (April 1 to date)

Please breakdown the total Other Services shown under the EISEP column on page 3 line 21 using the service categories provided. Complete the requested information for each service category in which the AAA provided services or goods during the period being reported. Include the number of persons served, the units provided and expenditures for the goods and/or services.

1. Home Modification(s) is a change to a particular location that fosters independence, safety or allows the person to carry out their daily tasks more easily (includes both or either materials and/or labor) – examples of this include but are not limited to installation of grab bar, widening door frame, building a ramp, lowering a counter, raising an electrical socket, installing a lighted door bell, replacing doorknobs with levers, accessible bath tub;

Unit – each modification includes all the materials and labor for each modification if the AAA provides both aspects of the modification, if the AAA only provides one component still count each component – materials for one modification or labor for one modification.

2. Home Maintenance/Repair intended to keep the person's home habitable and in good working order (includes both or either materials and/or labor) – examples of this include but are not limited to installing storm windows/screens, snow removal, lawn mowing, replace faucet, secure a loosened hand railing, and replace a step to the porch.

Unit – each maintenance or repair includes all the materials and labor for each maintenance job or repair if the AAA provides both aspects of the modification. If the AAA only provides one component, count each component – materials for each maintenance/repair job or labor for each maintenance/repair job.

3. Assistive Devices/Equipment, also referred to as assistive technology, that is intended to increase, maintain or improve functional capabilities of a person with limitations and thereby fosters a person's independence, safety and quality of life (includes the item and its installation, if required, and if the AAA includes both aspects) – examples of this include but is not limited to tub seat, lift vests, modified telephone (e.g., headset, large buttons, speakerphone), medication dispenser, chair lift, and/or stair glide.

Unit – each item, including installation, if required, and provided by the AAA.

4. Household Appliance is a household item that is needed to maintain the person in his/her home safely or will foster the person's independence and ability to carry out daily tasks more easily (include item and installation if required and provided by the AAA) – examples of this include but is not limited to stackable washer and dryer, air conditioner, microwave oven, toaster oven.

5. Miscellaneous Personal Items includes adaptive clothing, protective undergarments (for incontinence), adult diapers, cooking utensils, bedding, and/or adaptive silverware.

Unit/Item – each category/grouping provided to a client (e.g., adaptive silverware is one unit).

6. Other – anything that does not fit into one of the above categories and was included under "other services".

B. Cumulative Amount of Cost Sharing Accrued from EISEP/CSE Clients

1. - 2. (Before any transfers) enter the total amount of cost sharing collected or expected to be collected for services April 1 to date, regardless of when the cost share is actually received (i.e., on an accrual basis).
3. Enter the amount, if any, of EISEP cost sharing transferred to CSE.
Note: In subsequent quarters it will be necessary to adjust amounts in a, b, or c, for any accrued cost sharing previously reported which the AAA was not able to collect.

C. Non Registered Services (Cluster 3)

For cluster 3 (non-registered) services, **enter the estimated unduplicated count of persons served to date.** Estimates should reflect a reasonable estimate of actual persons served. Note this is an estimate and does not require demographic information to be collected.

D. Title VII Expenditures: Indicate **Federal** funds **only** spent this quarter on the accrual basis. Round expenditures to the nearest dollar. Remember to also include this amount on Page 3 Expenditures line 20 in the Other column. The amount reported on Page 3, line 20 in the Other column may exceed Title VII expenditures due to funding from other sources but it may not be less than Title VII expenditure.

E. State Transportation Information: Enter the units of transportations service, the total expenditures and program income provided this quarter under the State Transportation Program. (Refer to 06-PI-14 for additional information.)

F. Long Term Home Health Care Meals: Enter the number of home delivered meals sold to the Medicaid Long Term Home Health Care program during the quarter. Please include the funds expended on these meals on page 3, Part III, "Other" column, line 4. These meals cannot earn NSIP funding from NYSOFA. **Note the clients and services files submitted should reflect the meal counts reported here.**

G. Title V Expenditures:

- All data requested is for the quarter being reported.
- Do not include programs administered through National Sponsors for employment programs, e.g., N.C.O.A., Green Thumb, etc.
- Round all expenditures up to the nearest dollar and report whole dollars only. Non-Federal Matching Funds one cent or greater must be rounded up to the next dollar.
- Column A. Total accrued expenditures for the quarter being reported. The federal funds may not exceed 90% (rounded up) of the total expenditures.
- Column B, C, and D reflect appropriate breakdowns of the accrued expenditures reported in Column A.

Part III - Program, Services and Expenditure Breakdown - Federal\State Programs:

- The order of services is the same as the Service Delivery Objectives and Resource Allocation Plan page of the current Four Year and Annual Implementation Plans.
- Complete the lines for all services provided by the area agency and its subcontractors during the quarter.
- Expenditures for comprehensive assessments and reassessments conducted for non-case managed home delivered meals (HDMs) recipients and assessments for short term HDM recipients (Refer to 98-PI-25 for further information) may be reported on the case management line under SNAP on Page 3 as well as other programs as appropriate.

Amount of Funds Spent on an Accrual Basis This Quarter

- This column is divided into twelve sub-columns representing various funding sources provided by the area agency.
- Title VII data is included in the Other column, line 20 and on page 2, Part II. E.
- Shaded areas show where funds may not be used. See Technical Assistance Memo 82-TAM-III-B-6 (C-6) dated August 12, 1982 for further information on the use of III-C contributions to pay for the cost of supportive and access services.
- Expenditure data is reported on the accrual basis. **That is, expenditures are recorded when incurred and for the period for which benefit is received regardless of when the bill is received and/or payment is made.** When actual expenditures are not known in time to meet reporting deadlines, the area agency must provide estimated data on its Quarterly report. When estimates are needed for subcontractor expenses, the subcontractor should provide the estimates to the area agency.
- For Definitions of Services Units of Service see Standard Definitions for Service and Units of Service, 11-PI-03.
- All expenditure data must be rounded and reported to the nearest full dollar.
- For each funding source, the Total (line 23) must equal the sum of funding (lines 24, 25, 26 and 27), except for the "Other" column. It must also equal the sum of lines 1-22.
- Title III-E column(s)
 - All Funds - includes data for all expenditures for services provided under this program for all recipients.
 - Grandparents Only - Enter only Title III-E Grandparent services expenditures.
- On line 25 enter the total NSIP/Commodity Food expenditures utilized for that program.
- The minimum matching requirements for Titles III-B, III-C-1, III-C-2, III-D and III-E must be satisfied each quarter. Use the following method to calculate the minimum required Non-Federal share:

Take the amount of the Area Plan Administration costs (line 22) and multiply by 25% and round up to the nearest dollar. From the Total amount (line 23), subtract the total Area Plan Administration costs (line 22); also subtract Program Income (line 24), if any, since income can be used only to expand services. The resulting figure is the portion that must be matched on a 90%/10% basis and round up to the nearest dollar. Multiply this amount by 10% and round up to the nearest dollar and then add the result to the figure calculated from 25% of administrative costs. This gives you the minimum required Non-Federal Share for the Title III programs. See Worksheet, Section IV of these instructions, to determine minimum match requirements. Your Agency may provide more than the minimum required local match. In this case, refer to the approved budgets for the appropriate matching percentages. For Title III-D, this calculation is simplified because the funds cannot be used for Area Plan Administration.

- The minimum matching requirement for Title III-E must be satisfied each quarter. Take Total amount (line 23) subtract Program Income (line 24) and multiply the result by 25%. Round this amount up to the next dollar to get the minimum required local share.
- For Title III Programs, page 2, do not report any Program Income amounts on line 27a - Non-Federal Share (From Program Income). The Administration on Aging (AoA) has determined this to be ineligible as a source of match.
- Also, the amount reported on lines 24 and 27a. should equal the actual amount of program income collected during the reporting quarter. For the Community Services for the Elderly and Expanded In-home Services for the Elderly Programs, the breakdown of the Total Costs (line 23) on lines 24, 25 and 26 should be based on the following:
 - CSE/EISEP Planning/Implementation Costs (line 22) are 100% State Aid funded.
 - The sum of lines 24 and 27a. should equal the total amount of CSE/CSI/EISEP program income (contributions and accrued cost sharing) expended during the quarter. Please note, program income used as match under line 26a is limited to contributions only; CSE and EISEP cost sharing income may not be used as match. Accrued cost sharing under EISEP that is transferred to CSE should be reported in the CSE column on Line 24. Note that in subsequent quarters it will be necessary to adjust Line 27 for any accrued cost sharing previously reported that the AAA was not able to collect.
 - The Net Services Costs (line 23 minus line 22 minus line 24) are funded at 75% / 25%.
 - When calculating minimum required local match amounts, **always** round up to the next dollar. That is, Non Federal/State Share one cent or greater must be rounded up to the next dollar. If Non Federal/State Share is increased (rounded up), the Federal/State dollars must be decreased (rounded down).

Section II, General Requirements/Information for Client Specific Data

DATA REQUIREMENTS

1. AAAs are required to transmit client data for any Cluster 1, Cluster 2, Cluster 3 and Caregiver Clients (Title III-E) active as of **April 1, 2009** or subsequently added as a new client. Each quarter AAAs should generate data using these same criteria. This will allow new information entered during the latest quarter and any changes to existing data entered during the latest quarter to be captured using the same process. The data contained in these files provides information NYSOFA uses to meet both Federal and State reporting requirements as well as to perform necessary monitoring and assessment activities. The data in these files replaces the client and unit information previously collected as part of the CAARS quarterly system.

2. The following files are required for submission and must use the listed file names:

Clients.txt	Basic client identifying data, Nutrition Profile & NSI, Informal Supports, Financial Information, and Benefits/Entitlements (1 record per client)
Services.txt	Monthly units of service delivered (1 record per month per service per fund per client)
ADLIADL.txt	Client ADL/IADL needs (1 record per client)
Caregivers.txt	Caregiver type and relationship (1 record per client)
Characteristics.txt	Client Characteristics (1 record per characteristic per client)
Healthevents.txt	Hospital, emergency, physician visits, etc. (1 record per event per client)
Careplans.txt	Care Plan Services (1 record per service per client)
Elderabuse.txt	A record is required for each report of abuse.

3. Data must be sent to NYSOFA quarterly following the CAARS submission schedule.

4. NYSOFA will not require or store client names or Social Security Numbers in its centralized database. Therefore, these specifications do not include these fields as part of the AAA data submission to NYSOFA.

5. Reporting requirements are tied to the NAPIS cluster designations for services. Clusters are defined as follows:

Cluster 1 services: Personal Care Levels I & II, Home Health Aide, Home Delivered Meals, Adult Day Care Services and Case Management, Consumer Directed In-Home Services

Cluster 2 services: Congregate Meals, Assisted Transportation\Escort, and Nutrition Counseling

Cluster 3 services: Transportation, Legal Assistance, Nutrition Education, Information & Assistance, Outreach, In-Home Contact & Support, Sr. Center/Rec Education, Health Promotion, PERS, Caregiver Services, Other/Local

Caregiver\Grandparent Counseling/Support Groups/Training, Respite, Supplemental, Information, Access Assistance

6. Some files and/or data elements will be required for all Cluster 1, Cluster 2 and Caregiver service recipients; other files and/or data elements will be requested for clients receiving specific services. A Summary Table is provided in Attachment C - Fields Required by Cluster, showing which files are needed for each cluster. For example, data on ADL and IADL limitations will be required for Cluster 1 clients, but not for other clients.
7. Within specific files, some data elements will be required for all clients in the file and other data elements will be required only for those clients receiving services. For example, date of birth is required for all clients in the CLIENTS file. However, type of housing is required only for clients receiving Cluster 1 services.
8. Information on the number of participants at high nutritional risk is collected for all clients receiving Home Delivered Meals, Congregate Meals, Nutrition Counseling and Case Management using the NSI screen during the registration process or thereafter.
9. For both files and data elements, the following designations are used in Attachment A, File Specifications to note whether the information is required:
 - R Required for either NAPIS reporting or NYSOFA management/advocacy
 - M Information valuable to NYSOFA for ongoing monitoring, management and advocacy activities. If the data is available, NYSOFA would like to receive it from all AAAs from **April 1, 2009** forward. NYSOFA may require this information at a future date.
10. NYSOFA has begun reviewing its longer term data needs and may require additional data by client in the future in such areas as:
 - Client Care Plan Outcome Statements
 - Compliance with the Government Performance Results Act (GPRA)
 - Medications taken by client
 - Presenting problems
 - Nutrition related profile information such as use of nutritional supplements and ability to open containers
 - Frequency and occurrence of significant client events such as reassessments,
 - Historical/prior information to allow analysis of changes over time in such areas as:
 - Client characteristics
 - IADL/ADL needs
 - Nutritional status
 - Financial information
 - Benefits/Entitlements information

Technical Considerations

1. AAAs will be required to transmit **cumulative** client data for any Cluster 1, Cluster 2 and Caregiver \Grandparent clients **active** as of **April 2009** or subsequently added as a new client. Each quarter AAAs should generate data using these same criteria. This will allow both new information and

any changes entered during the latest quarter to be captured using the same process. NYSOFA will delete the AAA information on its centralized database and replace it with the new data files.

2. Each record on the CLIENT file will be used to establish a client record in the consolidated database. Each client receiving Cluster 1 and/or Cluster 2 and/or Caregiver/Grandparent services must be included on this file. Non-registered clients receiving only Cluster 3 services may be included on this file if they are part of the database. Clients receiving non registered services who are not registered will be reflected in the client file using the appropriate 9999..... anonymous record key.
3. Each client must have an assigned Record Number/KEY which is unique. This Record Number/KEY must be used consistently in all tables to link all data for the same client. The scheme used for this number is up to the AAA to determine.
4. Where data is coded, AAA data must be translated into the equivalent codes provided. For example, if a local data base contains a field 'marital status' with a code of 4 for 'widowed', it must be changed to a code of 2 to correspond to the appropriate coding scheme being used in NYSOFA's consolidated database.
5. Numeric fields should be right-justified and zero-filled. For example, a monthly income of \$455 should appear in the 5-character field as 00455.
6. All files are in standard ASCII (text) format with fixed length records.
7. Files are to be submitted using NYSOFA's FTP web site, <https://reporting.ofa.state.ny.us/>. This site uses the same username and password for access as you are currently using for the AAARIN website. Also, when going to this site you may be prompted to install a Java script. This is required as Java is used by the application. You may need IT support to do this install. Additionally you may see the prompt Continue to this website (not recommended). It is safe to go to this site. There is a Certificate Error but it is procedural and does not affect the safety of the site. Further instructions can be found on page 23 in this guide.
8. Data files no longer are to be submitted using a file compression utility such as WinZip. Only submit files in the required "text" format.
9. At this time it is not required that data be encrypted; however, AAAs wishing to do so should coordinate this effort with NYSOFA to insure that the data can be decrypted when received.
10. All files must conform to the Attachment A File Specifications for field length, characters used and file length.

Section III - Title III-E Service Matrix

<p>TITLE III-E SERVICE COMPONENTS with NAPIS Codes that <u>a caregiver receives</u> when receiving a Title III-E funded service.</p>	<p>CORRESPONDING NYSOFA STANDARD SERVICES that the <u>caregiver or care receiver is provided</u> in order to show the Title III-E component services and to provide a linkage to the CAARS expenditures.</p>
<p>Counseling, Support Groups & Training (Code 902)</p>	<p>Caregiver Services (Code 527)</p>
<p>Respite (Code 903)</p>	<p>PC Level II (Code 202) PC Level I (Code 205) Home Health Aide (Code 201) Adult Day Services--social adult day or adult day health (Code 510) In-home Contact and Support--when in-home supervision and monitoring will be provided (Code 526) Other--for those services not separately defined, e.g., overnight nursing home or adult home placement (Code 602)</p>
<p>Supplemental Services (Code 904)</p>	<p>Home Delivered Meals (Code 401) Congregate Meals (Code 402) Nutrition Counseling (Code 502) Assisted Trans./Escort (Code 504) Transportation (Code 101) Legal Assistance (Code 301) Nutrition Education (Code 501) Personal Emergency Response Systems (Code 509) Other--for those services not separately defined, e.g., home modifications, etc. (Code 603)</p>
<p>Assistance (Code 905)</p>	<p>Case Management (Code 505) Information and Assistance (Code 103)</p>
<p>Information (Code 906)</p>	<p>Outreach (Code 102) Other Services, i.e., Public Information (Code 604)</p>
<p>The CLIENT TYPES/FUNDING SOURCES codes for Title III-E services are 16 – III–E Caregiver and 20 – III–E Grandparent.</p> <p>Title III-E expenditures are reported on page 3 of the CAARS online form following the above crosswalk.</p> <p>Title III-E Other have been separated so they are tagged to the specific services.</p>	

Section IV - Minimum Match Determination Worksheet

Instructions to Determine Minimum Match Requirements - The minimum match requirements must be reported **each quarter**. The following formula must be followed and is designed to assist your determination of the **MINIMUM** amount required for Non-Federal Share under Titles III-B, III-C-1, III-C-2, and III-D(*):

(*): Please note for III-D, Area Plan Administration is not an allowable expense and should not be included in the calculation.

Step 1)	Line #22 Area Plan Admin.		=	_____
		x .25 (25%)		

				Figure 1
Step 2)	Line #23 Total			_____
	Minus Line #22 Area Plan Admin.		-	_____
	Minus Line #25 Program Income		-	_____

		Subtotal =		_____
		x .10 (10%)		
			=	_____
				Figure 2
Step 3)	Figure 1			_____
	Figure 2		+	_____

		MINIMUM REQUIRED MATCH	=	_____
Step 4)	Round this amount up, even if it is only one cent over the dollar. The Minimum Required Match must equal the Total of Lines 27a.-27b. Your reported match may be higher.			

For CSE and EISEP the formula to determine **MINIMUM** Non-State Share is:

Step 1)	Line #23 Total			_____
	Minus Line #22 Plan/Impl.		-	_____
	Minus Line #24 Program Inc.		-	_____

		Subtotal =		_____
		x .25 (25%)		

		MINIMUM REQUIRED MATCH	=	_____
Step 2)	Same as Step 4 in Title III formula.			

Section V, Reporting Tips

General Notes

If you use purchased software, **always be sure you are using the most recent version** of it and any additional tools that may be provided. In addition if your vendor provides intake forms such as those that are designed to meet the requirements of the NYS Compass form, make sure you are using the most recent version of those forms.

Information and Assistance

The reporting of persons served and services provided under Information and Assistance is certainly different than other services. Under I & A, a person may call and simply request information as to where a service is provided or where to go to find adult day services. In that case the person need not be counted and the anonymous code 9999999993 can be used; the unit of service, each contact is counted. The same person may call a different time and ask more detailed information about Adult Day Service. During that call the worker asks more information about the caller and the reason for the call. Using information received from the caller, the worker describes in detail the service and sets up a referral to a case manager. In this case the individual and the unit are reported.

Attachment A, Client Data Specifications

The file specifications outline the format to be used for each field. Failure to conform to the required format will result in errors and data not being processed. One example of this is the services file, which requires the count of units provided to be limited to ten spaces, 0000000.00. If this format is not followed we are unable to process that data. Additionally each of the files lists the county code as the first two spaces. AAAs are required to show only their county code. Incorrect County codes cannot be processed. Also the file names used must match the names used in the file specifications that are clients.txt, adliadl.txt, services.txt, healthevents.txt, characteristics.txt, careplan.txt, caregiver.txt **and elderabuse.txt.**

a. Client File

A number of questions have been added to follow changes in law. These additions have been highlighted in a several e-mails and have been added to the COMPASS form and instructions. The added\ revised questions are:

Creed which uses one of the following responses: 1=Christianity, 2=Islam, 3=Hinduism, 4=Buddhism, 5=Judaism, 6=Did Not Answer and 7=Other.

National Origin and list is provided in Attachment B Sec. H.

Sexual Orientation includes: 1=Heterosexual or Straight, 2=Homosexual or Gay, 3=Lesbian, 4=Bisexual, 5=Not Sure, 6=Did Not Answer and 7=Other. Information on this can be found in the COMPASS Instructions.

Transgender - Gender Identity or Expression = includes: 1=Male to Female, 2=Female to Male, 3=Did Not Answer, 4=No and 5=Did not answer. Information on this can be found in the COMPASS Instructions.

Marital Status now includes 3=Domestic Partner or Significant Other.

Does Client Participate in the following Programs - (Community Living Partnership, Chronic Disease Self Management Program, Integrated Systems Grant Part A and Other). What we are looking for here is to have a way to count clients who are enrolled under any one of these programs but whose services are being funded under another program. For example the services received by a Community Living Partnership client are funded under other programs such as EISEP.

Client Receiving Eligible Meals Who Are Otherwise Non-Eligible - (Under 60 Spouses of eligible seniors, Disabled Persons living in senior housing, USDA eligible volunteers under 60 and Disabled Persons living at home w\eligible person). Generally these meal recipients do not need to have an assessment done in order to receive a meal. Their meals can be reported using one of the allowable anonymous record keys. What has happen though is that when enough information is entered about them into the system to create a unique client ID our system reviews these clients looking for age and other information required for cluster 1 or cluster 2 clients. By coding these clients our system will know not to apply the data rules for registered clients. We will also be able to count for the first time how many meals are provided for example to disabled persons living in senior housing.

For required financial information there are three options; provide (1) Total Monthly Income, (2) Total Annual Income or 100% and 150% of the poverty level. If you provide either total monthly or total annual you must complete the "number in household" question.

If an older person declares they are age 60 or older but does not provide a date of birth, you may enter a date 60 years back.

Note when entering Overall cost share, this is to be entered as a percent and should not exceed 100 %.

b. ADL/IADL File

The statuses to be used for ADL/IADLs have been revised to read for ADL/IADL:

Totally Able – based on discussions with the client during the evaluation it is determined that the client is total able to perform the appropriate task with or without equipment.

Requires intermittent supervision and/or minimal assistance – client will occasionally need assistance performing a task. For example: clearing debris from an access ramp, assistance following a medical procedure or to have someone providing cueing/reminders to complete task.

Requires continual help with all or most of this task – client always needs assistance with this task. For example: cutting up food, adjusting equipment, etc.

Person does not participate; another person performs all aspects of this task – client is unable to perform this task. This may be due to culturally reasons such as housekeeping, laundry, etc. was always done by client's wife, client's cognitive or language difficulties make it impossible to do the task.

For further assistance please refer to the AAARIN website, look under Programs and by topic.

c. Health Events File

The data collected in this file has been useful in programmatic discussions with AoA. The primary field in this report is the Health Events Category. Possible responses for this field include in addition to Hospital Visit and Emergency Room; completion of PRI and DMS-1 forms, visits to a Physician or Clinic or Other. Also in order to see that no response is correct we have included the code 00 for No Event.

d. Care Plan File

We have added to the fields required to be reported the date the care plan was accepted and the response to the question if the client is Self directing/able to direct care. This has been added as it may indicate the client's ability to use consumer directed service under EISEP and other programs where this may be available.

This information is required for all clients receiving a Cluster 1 service. Where a client does not have any of the characteristics listed in Section F., Characteristic Information of Attachment B, an additional code 000 has been. Under Chronic Illness, additional categories have been added; 200 - High

e. Characteristics File

This information is required for all clients receiving a Cluster 1 service. Where a client does not have any of the characteristics listed in Section F., Characteristic Information of Attachment B, an additional code 000 has been. Under Chronic Illness, additional categories have been added; 200 - High Cholesterol, 201 - Frequent Falls and 952 HIV/AIDS. Under Cognitive Status 944 Hoarding has been added.

Also added as a possible characteristic are primary languages. The codes for this use the five top non English languages; 945 – Spanish, 946 – Chinese, 947 – Russian, 948 – Italian, 949 - French\Haitian Creole, 950 – Korean and 951 – Other. These need to be entered when a client is identified as having limit English proficiency.

f. Caregiver File

The caregiver file allows AAAs to report multiple caregivers and care receivers. Data fields in this file tag the client as being caregivers of older people who are 60 and over; caregivers of individuals of any age with Alzheimer's disease or related disorders; and, grandparents/older relatives who are at least 55 and caring for children. It also includes information showing the relationship to the care receiver. Note, that although multiple caregivers can be reported, reporting is not about the number of people that serve one person; it's about the number of people who are actually receiving respite services.

g. Elder Abuse File

This file has been added to capture incidents where a client has suffered one of the eight categories of abuse and to who agencies that client's call was referred.

Attachment B CODING STRUCTURE

B. STATUS / SUBSTATUS Codes

Status and sub status codes are used to show clients who are active and receiving services or who have become inactive or terminated.

A client in the program who is receiving services should be tagged as being an active client (1) and have a sub status code of either 20 = Case Managed or 35= Non Case Managed. See Att. L for examples of Case Managed\Non Case Managed recipients.

One example of this would apply to SNAP clients as the time spent doing the required assessment can be reported as a case managed service. Again, unless the case management service meets the Standard Definition of Service for Case Management, the client is not a case managed client so the client would be tagged as a Non Case Managed client.

A client who receives short term home delivered meals for example a person released from the hospital who receives a discharge plan that calls for a home delivered meal for two weeks. The plan is that the person will return to their daily routine after that time and no longer need the meal or the required assessment. The client in this example would not be a case managed client and would be tagged as a Non Case Managed client.

An additional example would be where an AAA provides a “shelf ready” emergency meal. If the person receiving the meal is not a registered home delivered meal client but would otherwise be program eligible, the meal would be counted as a NSIP eligible and the clients in this example would not be a case managed client and would be tagged as a Non Case Managed clients.

Another example is where an EISEP case manager may do an assessment for a potential client but for some reason that client does not become case managed. The AAA is allowed to count the time spent in doing the assessment as units of case management.

The following is a brief synopsis of what is required for case management.

For a client to be reported as a case management client, he/she must be receiving or expected to receive all the components of Case Management as found in the standard definition. Case management consists of assessment and reassessment, care planning, arranging for services, follow up and monitoring and discharge. These activities must be provided by or under the direction of the designated case manager or case manager supervisor. Standard Definitions (11-PI-03)

If a client has become inactive or terminated, please select from one of the sub status codes that best describes the reason why. You may need to contact your software vendor to learn how these selections are to be implemented.

D – SERVICES

The service codes have been added for ineligible meals so that 403 are for Ineligible Congregate and 404 are for Ineligible Home Delivered Meals. One use is to code meals that are ineligible and for consumers who are otherwise eligible. One example of seniors who are otherwise eligible is where a third party, such as a municipality pays a flat rate and seniors are **charged** for the meal. The seniors attending that center are 60+ and would be eligible but the meals are not USDA eligible because there is a charge.

Another change to keep in mind as a result of the movement of units of service from CAARS to the Client file is the way other services provided are coded.

For example Information & Assistance, Outreach and Other were services that when provided under HIICAP could be reported in CAARS on the appropriate service line with funds entered under the “Other” column. With the changes beginning April 1, a HIICAP funded unit of information & assistance could be reported using the service code of 103, funding type code of 21 and would use Record Key 9999999993.

Information & assistance provided under NYConnects would use the service code of 103, e funding type code of 24 and would use Record Key 9999999993.

Long Term Home Health Care Program Meals which are not eligible for NSIP funding would be coded as 403 for an ineligible congregat meal or 404 for an ineligible home delivered meal, a funding type code of 05 and would use Record Key 9999999991.

AAA Transportation Program units would be reported using a code as 101 with a funding type code of 05 and may also use Record Key 9999999995.

Anonymous record number/keys have been added for use when reporting Information, Other Information a Group 2 Service under Title III-E and for the general other category.

These are:

Other Services General (601)	9999999983 as the record number/key
Other Services III-E Information (604)	9999999984 as the record number/key

Other programs would be reported using the appropriate record key, service and funding type codes.

Coding for use in identifying non-registered participants in client and service

Non registered clients receiving only cluster 3 services are on page 2 of the online CAARS reporting web page and in the electronic client files.

For the client based reporting using the client.txt\ services.txt files, recipients of non-registered services who receive a Cluster 1 or Cluster 2 service can still be entered into the system using their unique identifying record key. AAAs will also have the option of using one of the 10 digit anonymous record keys provided in ATTACHMENT B, October 2012, CODING STRUCTURE. These codes need to be associated with the appropriate service to meet reporting requirements.

- | | | |
|---|---------------------|-------------------------------------|
| • Elder Abuse | Each contact | 9999999980 as the record number/key |
| • III-E Assistance | Each event/activity | 9999999982 as the record number/key |
| • Other Services General (601) | Each event/activity | 9999999983 as the record number/key |
| • Other Services III-E Information (604) | Each event/activity | 9999999984 as the record number/key |
| • In-Home Contact & Support | Each contact | 9999999985 as the record number/key |
| • Sr. Center Recreation/Education | One group session | 9999999986 as the record number/key |
| • Health Promotion | Each Participant | 9999999987 as the record number/key |
| • Personal Emergency Response (PERS) | One unit | 9999999988 as the record number/key |
| • Caregiver Services | Each Participant | 9999999989 as the record number/key |
| • USDA eligible seniors, spouses, disabled persons living in Senior Housing | Each meal | 9999999990 as the record number/key |
| • Guests/staff under 60 & other ineligible | Each meal | 9999999991 as the record number/key |
| • USDA eligible volunteers | Each meal | 9999999992 as the record number/key |
| • Information & Assistance | Each contact | 9999999993 as the record number/key |
| • Food handlers | Each meal | 9999999994 as the record number/key |
| • Transportation | One Way Trip | 9999999995 as the record number/key |
| • Legal | One hour | 9999999996 as the record number/key |
| • Outreach (Including III-E) | Each contact | 9999999997 as the record number/key |
| • Nutrition Education | Each Participant | 9999999998 as the record number/key |

Included in this list are also the codes to be used for some meal recipients.

The document, Attachment B, Coding Structure has been in place and in use since 2001. The codes for USDA eligible seniors, spouses, disabled persons living in Senior Housing, Guests/staff under 60 and Food handlers have been in place for that long as well. The code for USDA eligible volunteers under 60 is new.

All systems should have these codes available. We have found these codes to be under used in reported data. These codes are necessary when reporting Cluster 3 service information, anonymous congregate meals and for reporting ineligible meals now reported in CAARS. Contact your vendor or developer to ensure that the software allows the user to enter this information.

Examples for congregate meals codes:

If you serve a USDA eligible senior at say a picnic, and know the meal is eligible but do not have any identifying information about the senior except to know they're eligible, or serve a spouse of an eligible senior or a disabled person living in Senior Housing, then you can use the client file record key, 9999999990 representing that person and that same record key in the services file with the service code of 402.

If while doing a visit to a meal site and have lunch, you should be coding 9999999991 in the client file as a Guest or Staff under 60 and appear in the services file with that code and with the service code of 402.

A food handler working in the kitchen should be coded 9999999994 in the client file, and appear in the services file with that code and the service code of 402.

E. CLIENT TYPES/FUNDING SOURCES

In addition to the programs listed below, services provided may also be reported as being provided informally when necessary an informal support.

Allowable Service Expenditures by Fund*

The following table shows by service the allowable funds. Software settings should ensure that AAAs do not select incorrect funding type for services. Note page 3 of the CAARS online, provides a review of allowable costs by shading out those that are not allowable.

Services		Allowable Funds
PC Level II (H/PC)	One Hour	Title IIIB, Title IIIE, EISEP, CSE, Other , Vet, Infor
PC Level I (H/Chore)	One Hour	Title IIIB, Title IIIE, EISEP, CSE, Other, Vet, Infor
CD In-home Services	One Hour	EISEP, CSE, Other, Vet
Home Health Aide	One Hour	Title IIIB, Title IIIE, CSE, Other, Vet
Home Delivered Meals	One Meal	Title IIIC-2, Title IIIE, EISEP, CSE, SNAP, Other, Infor
Adult Day Services	One Hour	Title IIIB, Title IIIE, EISEP, CSE, Other, Vet
Case Management	One Hour	Title IIIB, Title IIID, Title IIIE, EISEP, CSE, SNAP, Other, Vet
Congregate Meals	One Meal	Title IIIC-1, Title IIIE, EISEP, CSE, SNAP, Other
Nutrition Counseling	One Hour	Title IIIC-1, Title IIIC-2, Title IIID, Title IIIE, EISEP, CSE, CSI, SNAP, Other, Vet
Assisted Trans.	One Way	Title IIIB, Title IIIC-1, Title IIIE, EISEP, CSE, CSI, SNAP, Other, Vet, Infor
Transportation	One Way	Title IIIB, Title IIIC-1, Title IIIE, EISEP, CSE, CSI, SNAP, Other, Vet, Infor
Legal Assistance	One Hour	Title IIIB, Title IIIE, CSE, Other, Vet
Nutrition Education	Each Participant**	Title IIIC-1, Title IIIC-2, Title IIID, Title IIIE, CSE, CSI, SNAP, Other, Vet
Info & Assistance	Each Contact	Title IIIB, Title IIIC-1, Title IIIC-2, Title IIID, Title IIIE, Title V, CSE, CSI, SNAP, HIICAP , LTCIEOP , POE , Other, HEAP, WRAP, MIPPA, Vet
Outreach	Each Contact	Title IIIB, Title IIIC-1, Title IIIC-2, Title IIIE, CSE, CSI, SNAP, HIICAP , LTCIEOP ,Other, Vet
In-Home Cont. & Sup.	Each Contact	Title IIIB, Title IIIC-1, Title IIIC-2, Title IIIE, EISEP, CSE, SNAP, Other, Vet, Infor
Sr. Center/Rec & Educ.	Group Session	Title IIIB, Title IIIC 1, Title IIID, CSE, CSI, SNAP, Other, Vet
Health Promotion	Each Participant	Title IIIB, Title IIID, Title IIIE, EISEP, CSE, CSI, MIPPA , Other, Vet
Per. Emerg. Response	One Unit	Title IIIB, Title IIIE, EISEP, CSE, Other, Vet
Caregiver Services	Each Participant	Title IIIB, Title IIID, Title IIIE, CSE, CSI, Other, Vet, Infor
LTC Ombudsman		Title IIIB, Other
Other Services	As Applicable	Title IIIB, Title IIIC-1, Title IIIC-2, Title IIID, Title IIIE, Title V, EISEP, CSE, CSI, SNAP, HIICAP , LTCIEOP , POE , Other, HEAP, WRAP, MIPPA, Vet, Infor

* For Title III-E services Refer to Standard Definitions of Service 2011

**Refer to Standard Definitions of Service 2011 for unit count information on distributed materials and media usage.

F. Nutrition Services Incentive Program (NSIP) Eligibility and Reporting

NSIP Eligibility:

Claimed Meals – all meals claimed for NSIP reimbursement must meet the nutritional requirements of the program (1/3 Dietary Reference Intake (DRI)). This extends to program variations such as the Restaurant Voucher option. In addition, if participants have been charged a fee or made to pay for a meal(s), those meals may not be claimed for reimbursement.

Congregate Meals

- People 60 years of age or older, and their spouses regardless of age.
- Volunteers who assist in the meal services during meal time.
- Disabled individuals under age 60 who reside at home with an eligible congregate participant.
- Individuals under age 60 with disabilities who reside in housing facilities occupied primarily by older individuals at which congregate meals are provided.

Home Delivered Meals

- Any person age 60 or older is eligible to receive home delivered meals provided that such person:
 - (i) is incapacitated due to accident, illness or frailty;
 - (ii) lacks the support of family, friends or neighbors; and
 - (iii) is unable to prepare meals due to a lack or inadequacy of facilities, or an inability to shop, cook or prepare meals safely, or a lack of knowledge or skill.
- The spouse of such a person, regardless of age, may receive home delivered meals if, according to criteria determined by the area agency, receipt of such meals is in the best interest of the eligible elderly person.
- Non elderly disabled persons living with an eligible person.
- Volunteers who assist in the meal services/deliver the home delivered meals can be provided a meal. The meal would be considered a NSIP eligible meal; the volunteer would not be considered a home delivered meals client.

NSIP Meals under National Family Caregiver Support Program (NFCSP)

- A caregiver who is a spouse, regardless of age, may receive a Congregate Meal/ HDM and have that meal counted for NSIP under IIC-1/ III-C2.
- A caregiver, who is not a spouse (but could be another family member) and is over 60, could receive a HDM, funded by Part E, Supplemental Services. **This meal would NOT be eligible for NSIP** (it does not meet the requirements for C-2 of the OAA and its regulations).
- A caregiver, who is not a spouse (but could be another family member) and is under 60, could receive a Congregate Meals /HDM funded by Part E, Supplemental Services. **This meal would NOT be eligible for NSIP.**
- Care receivers who receive a meal as a Supplemental service must also meet the definition of "Frail" in the Older Americans Act (see below).

Section 102: (A)(i) is unable to perform at least two activities of daily living without substantial human assistance, including verbal reminding, physical cueing, or supervision; or (B) due to a cognitive, or other mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or to another individual.

Source: Unofficial Compilation of the Older Americans Act as Amended in 2006

Reporting Eligible Meals:

To Report Home Delivered Meals (**Service Code = 401**) for:

- People 60 years of age or older must have their service information reported using their own Record Key.
- Spouses of the older people (under age 60) use 9999999990 code to enter service information.
- Eligible Volunteers, regardless of age, use 9999999992 code to enter service information.

To Report Congregate Meals (**Service Code = 402**) for:

- People 60 years of age or older must have their service information reported using their own Record Key.
- Spouses of the older people (under age 60) use 9999999990 code to enter service information.
- Disabled individuals (under age 60) use 9999999990 code to enter service information.
- Eligible Volunteers, regardless of age, use 9999999992 code to enter service information.

One point that makes the use of the 999999999x code Record Keys important is that, for example, a spouse who is eligible but under the age of 60 is entered and assigned a standard unique Record Key, NYSOFA's system will filter that person out and not count them because of their age.

Reporting Ineligible Meals:

Home Delivered/Congregate Meals (**Service Code = 403/404**) for:

- People under 60 (non-caregivers) and not eligible for NSIP meals use 9999999991 to enter service information.
- Other NSIP ineligible meals (e.g., LTHHCP (29)).
- Use these service codes for meals that are ineligible and for consumers whose meals are ineligible but they are otherwise eligible.

Reporting Caregiver Meals:

All caregivers who receive meals as supplemental services funded under IIIIE should have their own Record Key and use Service Code 904.

If a caregiver is program eligible or the spouse of care receiver and receives meals funded under IIIIE, the meal is NSIP eligible provided any other applicable program rules are met.

G. Reporting Websites

On April 19 an e-mail was sent notifying the AAAs that NYSOFA has been instituting a secure system for access to our web pages and applications. What does this mean for AAA users? It means that the user name and password first established for use with the AAARIN site will now be used for all NYSOFA web pages and applications. For those who do not have one and need it, a request can be made by the AAA Director through their ASR. User IDs and passwords are sent via US mail.

NYSOFA Budgeting and Reporting Systems

The CAARS Data Entry page has been revised. Area Agency staff will no longer be choosing a county and logging in with that county's password. Instead, staff will use their individual NYSOFA IDs and passwords to log in. Additionally, while the CAARS and AIP forms themselves will remain the same, the "look and feel" of the system will be changing. These changes will make the

system more user-friendly, accessible, and secure. The new link for this is:
<http://www.reporting.aging.ny.gov>.

NYSOFA Data Exchange

This site eliminates the need to use compressed (Zipped) files when submitting the associated client files to NYSOFA. Now the three required client and the three optional client data files can be submitted using a simple Windows click and drag method. This site will also be used when NYSOFA needs to transmit a file to an AAA that exceeds e-mail size limits. When copying a file from NYSOFA to your local computer you may experience “Transfer Failed” before it reaches 100%. There can be many reasons for this. Simply try it again, the software will continue the transfer at the point it failed. In the future, an e-mail will be sent to the AAA advising them that the approved AIP is in their county folder and available for download. The link for this site is:
<https://reporting.ofa.state.ny.us/>.

NYSOFA Report Viewer

NYSOFA has long had a policy of providing reports using the data submitted using the CAARS, AIP, and recently the client files. Currently these reports are created after the majority of reports have been received from the AAAs and made available as a PDF file on the AAARIN site under Reporting. In the past users were able to run units of service and expenditures reports from the CAARS Data Entry pages. Using this site allows authorized users to select a report, select their county and time period and run the report. These reports can be printed or exported to a PDF file or MS Excel format. The link for this site is:
<http://www.boedmz.ofa.state.ny.us/infviewapp/logon.aspx>

Section VI - County Codes

County	County	County
01 Albany	22 Jefferson	42 Schenectady
02 Allegany	23 Lewis	43 Schoharie
03 Broome	24 Livingston	44 Schuyler
04 Cattaraugus	25 Madison	45 Seneca
05 Cayuga	26 Monroe	46 Steuben
06 Chautauqua	27 Montgomery	47 Suffolk
07 Chemung	28 Nassau	48 Sullivan
08 Chenango	29 Niagara	49 Tioga
09 Clinton	30 Oneida	50 Tompkins
10 Columbia	31 Onondaga	51 Ulster
11 Cortland	32 Ontario	52 Warren/Hamilton
12 Delaware	33 Orange	53 Washington
13 Dutchess	34 Orleans	54 Wayne
14 Erie	35 Oswego	55 Westchester
15 Essex	36 Otsego	56 Wyoming
16 Franklin	37 Putnam	57 Yates
17 Fulton	38 Rensselaer	60 New York City
18 Genesee	39 Rockland	62 Seneca Nation
19 Greene	40 St. Lawrence	63 St Regis/Mohawk
21 Herkimer	41 Saratoga	

Section VII - Glossary of Terms

Accrual Basis - Expenditures are recorded when incurred and for the period for which benefit is received regardless of when the bill is received and/or payment is made.

Advocacy/Related Services - The monitoring, evaluating, and commenting on policies, programs, hearings, levies and community actions which affect older people. This includes conducting public hearings on the needs of older people, the representation of the interests of older people to public officials, public and private agencies and organizations, and coordinating planning with other agencies and organizations to promote new or expanded benefits and opportunities for older people.

Area Plan Administration - Costs incurred by the area agency for administering the Area Plan. This includes planning activities as well as on-going administrative and oversight efforts.

Caregiver – An adult family member or another individual, who is an “informal” provider of in-home care to an older individual. “Informal” means that the care is not provided as part of a public or private formal service program. For further information refer to Attachment H.

Case Managed Client – is a person who has accepted their care plan and for EISEP clients, has signed the Financial Information & Client Agreement and who receives follow-up and monitoring which provides for contact every two months.

Child – An individual who is not more than 18 years of age (Including children with disabilities) and children with disabilities between the ages of 19 and 59. This term relates to a grandparent or other relative who is a caregiver of a child.

Community Services for the Elderly/Expanded In-home Services for the Elderly Program Planning & Implementation - Costs incurred by the area agency for Plan preparation and revision; evaluation of projects conducted under the Plan, execution of interagency agreements necessary to carry out the Plan; administrative actions to consolidate or combine services or relocate separate services into one location; ongoing management supervision of all activities conducted under the Plan including: accounting, budgeting, record keeping, staff salaries, fringe benefits, consultant services, space, equipment and supplies, utilities and other related costs approved by the NYSOFA Director.

Congregate Meal - A hot or other appropriate meal which meets nutritional requirements and is served in a group setting.

Domestic Violence

Domestic violence, also known as domestic abuse, spousal abuse, battering, family violence, and intimate partner violence (IPV), is broadly defined as a pattern of abusive behaviors by one or both partners in an intimate relationship such as marriage, dating, family, or cohabitation. Domestic violence, so defined, has many forms, including physical aggression or assault (hitting, kicking, biting, shoving, restraining, slapping, throwing objects), or threats thereof; sexual abuse; emotional abuse; controlling or domineering; intimidation; stalking; passive/covert abuse (e.g., neglect); and economic deprivation.

Elder Abuse*

- **Physical abuse:** Non-accidental use of force that results in bodily injury, pain, or impairment. This includes, but is not limited to, being slapped, burned, cut, bruised or improperly physically restrained.
- **Sexual abuse:** Non-consensual sexual contact of any kind. This includes, but is not limited to, forcing sexual contact with self or forcing sexual contact with a third person.

- **Emotional abuse:** Willful infliction of anguish, pain, or distress through verbal or non-verbal acts. This includes, but is not limited to, isolating or frightening an adult.
- **Financial exploitation:** Improper use of an adult's funds, property, or resources by another individual. This includes, but is not limited to, fraud, embezzlement, forgery, falsifying records, coerced property transfers, or denial of access to assets.
- **Intentional Neglect:** Failure to meet the needs of the dependent elderly person by, for example, willfully withholding food or medications or refusing to take the elder to seek medical care.
- **Unintentional Neglect:** Neglect that involves ignorance or from genuine inability to provide care.
- **Self Neglect:** This is the adult's inability, due to physical and/or mental impairments, to perform tasks essential to caring for oneself.
- **Abandonment:** Desertion of a vulnerable elder by anyone who has assumed care or custody of that person.

* Social Services Law. § 473 and NY Codes, Rules and Regulations, 18 NYCRR § 457.1.

Eligible Meal – Eligible meals are those served to persons age 60 and older, the spouse of someone age 60 regardless of age, and disabled persons under age 60 who reside in a housing facility occupied primarily by the elderly where congregate meals are served. This includes staff age 60 and older, and all volunteers. individuals with disabilities who reside at home with older individuals.

Note: participating area agencies on aging may establish procedures that allow nutrition project administrators the option to offer a meal, on the same basis as meals provided to participating older individuals, to individuals providing volunteer services during the meal hours, and to individuals with disabilities who reside at home with older individuals eligible under this chapter, Section. 339. NUTRITION. (H) of the OAA.

Note that staff and volunteers who are program eligible should be registered so that all appropriate information may be reported. For further information on this, please refer to 90-PI-26 Revised Nutrition Program Standards.

Disabled - Any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment. This includes alcoholism and drug addiction. Note, all EISEP clients are considered to be frail/disabled.

Focal Point - A place or mobile unit in a community or neighborhood designated by the area agency for the collocation and coordination of services.

Frail - A person with one or more functional deficits in the following areas:

- Physical functions
- Mental functions
 - Activities of Daily Living [ADL] (eating, bed/chair transfer, dressing, bathing, toileting and continence).
 - Instrumental Activities of Daily Living [IADL] (meal preparation, housekeeping, shopping, medications, telephone, travel and money management).

Grandparent or other older relative caregiver of a child – A grandparent, step grandparent or other relative of a child by blood, marriage, or adoption who is 55 years of age or older and;

- (A) lives with the child;
- (B) is the primary caregiver of the child because the biological or adoptive parents are unable or unwilling to serve as the primary caregiver of the child; and
- (C) has a legal relationship to the child, such as legal custody or guardianship, or is raising the child informally.

for further information refer to Attachment H.

High Nutritional Risk – An individual who scores (6) or higher on the Nutrition Risk Checklist.

Home Delivered Meal - A hot or other appropriate meal, which meets nutritional requirements and is provided to an eligible person for home consumption.

Impairment in Activities of Daily Living (ADL) -The inability to perform one or more of the following seven activities of daily living without personal assistance, stand-by assistance, supervision or cues: Bathing, Personal Hygiene, Dressing, Mobility, Transfer, Toileting and Eating.

Impairment in Instrumental Activities of Daily Living (IADL) - The inability to perform one or more of the following eight instrumental activities of daily living without personal assistance, or stand-by assistance, supervision or cues: Housework/cleaning, Shopping, Laundry, Use transportation, Prepare & cook meals, Handle Personal business/finances, Use Telephone and Self-administration of medications.

Ineligible Congregate - Meals served to paid staff under age 60, guests under age 60 of provider and monitoring agencies. Include meals served to other people who do not meet the requirements for becoming a participant; i.e., who are not age 60 or older or who are not the spouse of a person 60 or older.

Limited English Proficiency - Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English can be limited English proficient, or "LEP."

Low Income/Poverty - An income level at or below 150% of the poverty threshold for Community Services for the Elderly Program, Expanded In-home Services for the Elderly Program recipients and Supplemental Nutrition Assistance Program recipients, and 100% of the poverty threshold for Title III recipients as established by the Bureau of the Census.

Minority Provider – A provider of services to clients which meets any one of the following criteria: 1) A not for profit organization with a controlling board comprised at least 51% of individuals in the racial and ethnic categories listed below. 2) A private business concern that is at least 51 percent owned by individuals in the racial and ethnic categories listed below. 3) A publicly owned business having at least 51 percent of its stock owned by one or more individuals and having its management and daily business controlled by one or more individuals in the racial and ethnic categories listed below. The applicable racial and ethnic categories include: American Indian or Alaskan Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, or Hispanic.

Multi-Purpose Senior Center Facility - means a community facility for the organization and provision of a broad spectrum of services, which shall include provision of health (including mental health), social, nutritional, and educational services and the provision of facilities for recreational activities for older individuals.

Nonprofit - as applied to any agency, institution, or organization means an agency, institution, or organization which is, or is owned and operated by, one or more corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

Nutrition Services - will be available to older individuals and to their spouses, and may be made available to individuals with disabilities who are not older individuals but who reside in housing facilities occupied primarily by older individuals at which congregate nutrition services are provided, under this chapter, Section. 339. NUTRITION. (I) of the Older Americans Act of 1965 as Amended In 2006 (Public Law 109-365).

Older Individual - means an individual who is 60 years of age or older

Race/Ethnicity – Those individuals belonging to one of the following groups: American Indian/Alaskan Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or other Pacific Islander.

- American Indian or Alaskan Native - A person having origins in any of the original peoples of North America (including Central America), and who maintains cultural identification through tribal affiliation or community recognition.
- Asian - A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian Subcontinent. This area includes, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.
- Black or African American - A person having origins in any of the black racial groups of the original peoples of Africa.
- Native Hawaiian or Other Pacific Islander - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or the Pacific Islands.
- Hispanic or Latino - A person of Cuban, Mexican, Puerto Rican, Central or South American or other Spanish culture or origin, regardless of race.
- White Hispanic - People who identify their origin as Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin.
- White – A person having origins in any of the peoples of Europe, the Middle East or North Africa.

Personnel Categories by Functional Responsibilities

- Agency Executive/Management Staff - Personnel such as the area agency director or deputy directors of key divisions and other positions which provide overall leadership and direction to the agency.
- Other Paid Staff - Personnel who are considered professional staff who are not responsible for overall agency management or direction setting but carry out key responsibilities or tasks associated with the area agency in the areas listed below:
 - Planning - Includes needs assessment, plan development, budgeting/resource analysis, service inventories, standards development and policy analysis.
 - Development - Includes public education, resource development, training and education, research and development and legislative activities.
 - Administration - Includes bidding, contract negotiation, reporting, reimbursement, accounting, auditing, monitoring, information system activities and quality assurance.
 - Service Delivery - Includes those activities associated with the direct provision of a service which meets the needs of an individual older person and/or caregiver.
 - Access/Care Coordination – Includes outreach, screening, assessment, case management and I & A.

- Clerical/Support Staff - All paid personnel who provide support to management and professional staff.
- Volunteer - See below.

Registered Client – A registered client is an individual who received at least one unit of the following specified services within the reported fiscal year. The services include: congregate meals, nutrition counseling, assisted transportation, personal care level I, personal care level II, home delivered meals, adult day care, case management, consumer directed in-home.

Rural – For the purpose of reporting, a rural area is: any area that is not defined as urban. Urban areas comprise (1) urbanized areas (a central place and its adjacent densely settled territories with a combined minimum population of 50,000) and (2) an incorporated place or a census designated place with 20,000 or more inhabitants.

Rural Subcontractor – Providers of services to clients who live in rural areas. Rural providers are not necessarily providers of service only to rural clients. They may also be providers of services to clients in urban areas.

Terminated/Inactive - clients have not used any aging network services for more than 12 consecutive months.

Veteran - A man or woman who served on active duty in the armed forces of the United States and who was discharged or released under conditions other than dishonorable.

Volunteer - A volunteer is a person who performs a service without financial compensation for an individual or community organization. A volunteer may also assist the area agency in carrying out its responsibilities either in direct service provision or any of its planning, development, administration, access/care coordination roles.

The time of the volunteer service is measurable in increments of 15 minutes, so as to be able to determine the FTEs.

Supporting Document List

86-PI-54	EISEP - County Home Care Plan for the Functionally Impaired Elderly
89-PI-03	Provision of Meals to Disabled Persons Residing with Elderly Participants
90-PI-26	Revised Nutrition Program Standards
90-PI-40	Revised Page 5 and 6 of the Nutrition Standards 90-PI-26
91-IM-72	Mandated Aging Services
91-IM-84	Personal Emergency Response Systems (PERS)
97-PI-01	Assessment Data Collection Requirements
97-PI-19	CAARS Reporting Forms & Instructions (Reporting HDM assessments as Case Management)
97-PI-20	Program and Policy Changes Related to Implementation of MDS (6 Month HDM Reassessment)
97-IM-24	Final - COMPASS
97-IM-24	Att. 1- COMPASS Intake Information
97-IM-24	Att. 2 - COMPASS Instructions
97-IM-32	Community Based Long Term Care Minimum Data Set -Questions and Answers #1
97-IM-36	Community Based Long Term Care Minimum Data Set -Questions and Answers #2
97-IM-54	Community Based Long Term Care Minimum Data Set -Questions and Answers #3
98-PI-25	Guidelines for Conducting Short Term Home Delivered Meal Assessments
97-TAM-06	Determining Meal Costs
99-PI-21	Revised Regulations for the Nutrition Program and the Expanded In-home
00-TAM-02	Services for the Elderly Program -- Final Rule Making
03-PI-05	NYSOFA Policy on Program Income
03-PI-10	FFY 2003 Title III Transfers, Carryover and Budget Modifications
06-PI-14	AAA Transportation Program
07-IM-03	Title III Intra-state Funding Formulas (IFFs)
09-PI-14	ARRA Section 1512 Reporting and Other Reporting Requirements
10-PI-05	Revised Maximum Housing Adjustment for 2010 Financial Levels for EISEP and CSE
10-PI-06	Preparing to Implement Regulatory Changes for EISEP or CSE-funded EISEP-like Ancillary Services
11-PI-02	2011 Poverty Income Guidelines
11-PI-03	Standard Definitions for Service and Units of Service
12-PI-07	CAARS Client Forms and Instructions, Revised
	Reporting Guide CAARS and Client Data
	CAARS Quarterly Report Forms,
	Attachment A - Client Data Specification
	Attachment B – Coding Structure
	Attachment C - Fields Required by Cluster
	Attachment D - Instructions for Comprehensive Assessment for Aging Network
	Community-Based Long Term Care Services
	Attachment E - COMPASS
	Attachment F - Title III-E Program Frequently Asked Questions
	Attachment G - Title III-E Reporting Scenarios
	Attachment H – Definitions of Caregiver, Counseling and Assistance under Title III-E
	Attachment I – Title III-E Coding Examples
	Attachment J – Client Status
	Attachment K - CAARS\Client Reports 2011
	Sample Congregate Services Intake Form/Sample III-E Registration Form

Area Agency Quarterly Report

Area Agency: _____

NYSOFA #358 Rev. (04/2013) New York State Office for the Aging

Part I - Operations

A. Period Covered -

Report is: Original

Revision

Date Submitted:

Quarter Reported:

1st:

2nd:

3rd:

4th:

B. Identification

1. Area Agency: _____

2. Code: _____

3. Completed by: _____

4. Title: _____

5. Area Code & Phone: _____

6. Email Address: _____

7. Director Review

C. Staffing

(Submit with quarter ending June 30th)

AAA Staffing: Develop the following staffing profile of the AAA as of June 30th for filled positions only.

For personnel classifications definitions, refer to Section VII, Glossary of Terms.

AAA Personnel Categories	Full Time Equivalent(s)	
	No. of FTEs	No. of Minority FTEs
1. Exec./Man. Staff		
2. Other Paid Professional Staff (By Functional Responsibility)		
a) Planning		
b) Development		
c) Administration		
d) Service Delivery		
e) Access/Care Coord.		
f) Other		
3. Clerical/Support Staff		
4. AAA - Volunteers		
5. Subcontractor - Volunteers		
6. Total		

D. Provider Profile:

(Submit with quarter ending March 31st)

a. Total Number of Subcontractors: _____

c. Total Number of Min. Subcontractors: _____

b. Total Number of Rural Subcontractors: _____

E. Focal Points/Senior Centers:

(Submit with quarter ending March 31st only)

1. Total number of Senior Centers in planning & service area:	
2. How many centers received Title III funds during the past state fiscal year?	
3. How many centers are designated as focal points?	
4. Total number of focal points operating in the county during the past fiscal year:	

Part II - Program Information

A. EISEP Other Services (April 1 to date)

Please breakdown the total Other Services shown under the EISEP column on page 3 line 21. Complete the requested information for each service category in which the AAA provided services or goods during the period being reported. Include the number of persons served, the units/items provided and expenditures for the goods and/or services.

Goods and Services	Persons Served	Units	Expenditures
1. Home Modifications			
2. Home Maintenance\Repair			
3. Assistive Devices/Equipment			
4. Household Appliances			
5. Misc. Personal Items			
6. Other Describe			

Area Agency: _____ Report is: [] Original [] Revision Date Submitted:
 Quarter Reported: [] 1st: [] 2nd: [] 3rd: [] 4th:

Part II - Program Information Continued (Complete Each Quarter)

B. Cumulative amount of Cost Sharing funds accrued from EISEP/CSE clients

April 1 to date:

1. CSE Cost Sharing _____ 2. EISEP Cost Sharing _____
 3. EISEP Cost Sharing Transferred to CSE _____

C. Non Registered Services

a. For the following services excluding Title III E, enter the estimated unduplicated count of persons served to date

1. Transportation		7. Sr. Center Rec./Ed.	
2. Legal Services		8. Health Promotion	
3. Nutrition Education		9. PERS	
4. Information & Assistance		10. Caregiver Services	
5. Outreach		11. Other	
6. In-Home Contact & Support		12. Total Non-Registered Persons Served	

b. For the following Title III E funded services, enter the estimated audience size

1. Information		2. Assistance	
----------------	--	---------------	--

D. Title VII Expenditures (Indicate Federal funds only spent this quarter on the accrual basis.)

(Round expenditures to the nearest dollar.)

Amount of Title VII funds spent on LTCOP Ombudsman activities this quarter: _____

(Do not include State LTCOP expenditures here.)

E. State Transportation Information

Enter the units of transportation service, State Funds, Program Income and Local Funds expended this quarter under the State Transportation program (Total funds will be caclulated). Report expenditures in whole dollars only. (Refer to 06-PI-14 for additional information.)

A. Units Provided	B. Total Expend.	C. State Funds Expended	D. Program Income	E. Local Funds Expended

F. Long Term Home Health Care Program Meals:

Enter the number of home delivered meals sold to the Medicaid Long Term Home Health Care program during the quarter: _____

Please include the funds expended on these meals on page 3, Part III, "Other" column, line 4. These meals can not earn NSIP funding from NYSOFA.

G. Title V Expenditures (Do not include programs administered through national sponsors)

Indicate funds spent this quarter on the accrual basis under the AAA's directly operated/subcontracted NYSOFA funded Title V Program. **Report expenditures in whole dollars only.**

Budget Category	A. Total	B. Administration	C. Enrollee Wages & Fringe Benefits	D. Other Enrollee Costs
1. Total Expenditures	0			
2. Federal Share Expended	0			
3. Non-Federal Matching Funds Expended	0			

Area Agency: _____ Report is: Original Revision Date Submitted: _____
 Quarter Report 1st: 2nd: 3rd: 4th:

Part III - Program Services Expenditure Breakdown - Federal/State Programs

Amount of Funds Spent on an ACCRUAL Basis this Quarter (Whole Dollars Only)

Service Categories	Grand Total	Title III-B ¹	III-C-1 ^{2,3}	III-C-2 ^{2,3}	III-D	III-E ⁵ (All Funds)	III-E ⁹ (Grand-parent Only)	EISEP ^{4,5}	CSE	CSI	SNAP ⁵	Other ⁶
1 a. PC Level II (H/PC)												
b. PC Level I (H/Chore)												
2 CD In-home Services												
3 Home Health Aide												
4 Home Delivered Meals												
5 Adult Day Services												
6 Case Management												
7 Congregate Meals												
8 Nutrition Counseling												
9 Assisted Trans./Escort												
10 Transportation												
11 Legal Assistance												
12 Nutrition Education												
13 Info & Assistance												
14 Outreach												
15 In-Home Cont. & Sup. ²												
16 Sr. Center/Rec & Educ.												
17 Health Promotion												
18 Per. Emerg. Response												
19 Caregiver Services												
20 LTC Ombudsman ¹												
21 Other Services ⁷												
22 Area Plan Admin/Plan Implmentation/Admin												
23 TOTAL	0	0	0	0	0	0	0	0	0	0	0	0
24 Program Income												
25 NSIP/Commodity Food												
26 Federal Share												
27 Non Federal Share												
a. from Program Income												
b. Other Sources												

1. IIIB column, line 20 does not include Title VII. Include Title VII in "Other" column and show on page 2, Part II, E.
2. Only III-C contributions may be used to pay for the cost of supportive and access services.
3. Title IIIC-1 & IIIC-2 column, line 15 can only be used for Shopping Assistance.
4. EISEP column, line 5, is for Non-Institutional Respite only.
5. SNAP column, line 15, Shopping Assistance only. EISEP column, line 15, is for Supervision Level-Non Institutional Respite only.
6. Other column includes Foster Grandparents, HEAP, WRAP, Title V, Title VII, State LTCOP, CRC, Grants-in Aid, RSVP, HIICAP, Title XIX/XX, other locally funded programs etc.
7. EISEP column, line 21 includes all allowable ancillary services not listed on Lines 4,7,8,9,10,17 & 18.
8. Include all Title III E expenditures including Grandparent services. Other Services includes all other services.
9. Enter only Title III E Grandparent services expenditures.

COMPASS – Compressive 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 (04/13) COMPASS - Comprehensive Assessment for Aging Network Community Based Long Term Care Services

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.

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"/>							
Reads	<input type="checkbox"/>							
Understands orally	<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: (Check all that apply)

Alone With Spouse With Spouse & others With Relatives With Non-Relative(s), Domestic Partner Others

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:

II HOUSING STATUS

A. Type of Housing Check):

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

Detector 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"/> paralysis |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> digestive problems* | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> anorexia | <input type="checkbox"/> diverticulitis | <input type="checkbox"/> Pernicious anemia |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> fractures (recent) | <input type="checkbox"/> renal disease |
| <input type="checkbox"/> cancer | <input type="checkbox"/> frequent falls | <input type="checkbox"/> respiratory problems |
| <input type="checkbox"/> cellulitis | <input type="checkbox"/> gall bladder disease | <input type="checkbox"/> shingles |
| <input type="checkbox"/> chronic obstructive pulmonary disease (COPD) | <input type="checkbox"/> hearing impairment | <input type="checkbox"/> smelling impairment |
| <input type="checkbox"/> chronic pain | <input type="checkbox"/> heart disease | <input type="checkbox"/> speech problems |
| <input type="checkbox"/> colitis | <input type="checkbox"/> hiatal hernia | <input type="checkbox"/> stroke |
| <input type="checkbox"/> colostomy | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> swallowing difficulties |
| <input type="checkbox"/> congestive heart failure | <input type="checkbox"/> high cholesterol* | <input type="checkbox"/> taste impairment |
| <input type="checkbox"/> constipation | <input type="checkbox"/> hypoglycemia | <input type="checkbox"/> traumatic brain injury |
| <input type="checkbox"/> decubitus ulcers | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> tremors |
| <input type="checkbox"/> dehydration | <input type="checkbox"/> legally blind | <input type="checkbox"/> ulcer |
| <input type="checkbox"/> dental problems* | <input type="checkbox"/> liver disease | <input type="checkbox"/> urinary Tract infection |
| <input type="checkbox"/> developmental disabilities | <input type="checkbox"/> low blood pressure | <input type="checkbox"/> visual impairment |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> other (Specify) |
| <input type="checkbox"/> dialysis | <input type="checkbox"/> oxygen dependent | |

*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 |

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?

- (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)

Month: Year

___PRI Score:

Completed by: _____
(Name and Affiliation)

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

F. Does the person have a physician prescribed modified therapeutic diet Yes No

(If yes, check all that apply)

Texture-Modified Calorie Controlled Diet Sodium Restricted

Fat Restricted High Calorie Renal

Other {Specify}

(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
Person an illness or conditions that made me change the kind and/or amount of food I eat.	2
Eats fewer than 2 meals per day.	3
Eats few fruits or vegetables, or milk products.	2
Has 3 or more drinks of beer, liquor, or wine almost every day.	2
Has tooth or mouth problems that make it hard for me to eat.	2
Does not always have enough money to buy the food I need.	4
Eat alone most of the time.	1
Take 3 or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I lost or gained 10 or more pounds in the last 6 months.	2
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 AND OVER THE COUNTER MEDICATIONS CURRENTLY TAKEN

A. MEDICATIONS.

Name	Dose/Frequency	Reason Taken

B. Primary Pharmacy Name Phone

C. Does the person have any problems taking medications?
 Adverse reactions/allergies/sensitivities Yes, if Yes. Describe No

Cost of medication Yes, if Yes. Describe No

Obtaining medications Yes if Yes. Describe No

No Other (Describe):

Comments

**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.

Check if assistance is/will be provided by

Activity: What can person do?	Enter Person's Activity Status	Activity Status	Informal Supports	Formal Services	Comments: Describe limitations, parts of tasks to be done and responsibilities of informal supports and 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					
ARE CHANGES IN IADL CAPACITY EXPECTED IN THE NEXT 6 MONTHS? <input type="checkbox"/> Yes (If Yes describe) <input type="checkbox"/> 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

	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,				

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)
- 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?
 B. Yes No (If No, skip to question D 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 person appear to have a good relationship with this person
-
- Yes
-
- No

(Explain)

1. b. Would the person accept help, or more help, from this person 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 person's Involvement? (Check all that apply)

 job finances family responsibilities physical burden transportation emotional burden health problems reliability living distance

1. d. Is Caregiver relief needed?
-
- Yes
-
- No

If yes, when?

 Morning Afternoon Evening Overnight Weekend Other

1. e. Would this person be considered the caregiver?
-
- 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 person appear to have a good relationship with this person? Yes No
(Explain)

2. b. Would the person accept help, or more help, from this person in order to remain at home and/or maintain Independence? (Check one)
 willing to accept help (Describe)
 unwilling to accept any help (Describe)

2. c. Are there any factors that might limit this person's involvements (Check all that apply)

job finances family responsibilities physical burden transportation
 emotional burden health problems reliability living distance

2. d. Is Caregiver relief needed? Yes No

If yes, when? Morning Afternoon
 Evening Overnight
 Weekend Other

2. e. Would this person be considered the caregiver? Yes No

C. Can other Informal supports) provide temporary care to relieve the caregiver(s)? Yes (if yes, describe) No

D. 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
Social Security (net)	\$
SSI	
Personal Retirement Income	
Interest	
Dividends	
Salary/Wages	
Other	

B. Total Monthly Income \$

C. 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		
WRAP		
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	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 (If applicable): _____ 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)

- Goal Met: (Specify)
- Independence
- Client Request
- Client Relocated
- 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

Instructions

COMPASS

**(Comprehensive Assessment for Aging
Network Community-Based Long Term Care Services**

April 2013

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INSTRUCTIONS

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

INTRODUCTION

The Comprehensive Assessment for Aging Network Community-Based Long Term Care Services (COMPASS) is designed to be a useful client assessment instrument that will inform and guide comprehensive care planning. It provides the basis to determine the need for AAA-funded services, as well as referrals to other programs and providers when appropriate. The COMPASS is intended to reflect the critical role informal caregivers play in the client's plan of care and to gather information to develop a care plan that focuses on goals and objectives to address identified problems or needs.

This version of the COMPASS contains the Minimum Data Set (MDS) that all assessment instruments for aging-funded community-based long term care are required to include as of April 1, 1999.

The person being assessed has certain rights in regards to the assessment process. It is important that the assessor and the person know these rights. The assessor has the responsibility to inform the person of their rights. The person being assessed must be told:

- Why the assessment is being conducted;
- Why the information is being requested;
- How the information will be used; and
- That he/she has a right to refuse to provide information.

If a person refuses to provide some information in response to a question asked by the assessor, he/she must be told:

- It may be possible to provide services to him/her based on the information that is provided, but
- Failure to provide all the information requested could result in the person not receiving the services he/she wants or those services most appropriate to meet his/her needs.

If the inability to provide services to a person is due to the person failing to provide adequate information, the person should be notified of that fact.

All information gathered during the assessment process, including that contained in the assessment document, is confidential. This information should be shared with others only as needed. The person must be informed that information will be shared with others as necessary to implement the care plan and to comply with program requirements, including but not limited to monitoring, research and evaluation.

GENERAL CONCEPTS

USE THESE INSTRUCTIONS --- Read these instructions before completing the COMPASS. Keep them with the COMPASS as assessments are completed. ***Frequent reference to these instructions will aid in accurately completing the COMPASS.***

USE ONLY THE DEFINITIONS WITHIN THESE INSTRUCTIONS --- Different types of assessment instruments are used for specific reasons and programs. Consequently, they often require different definitions. ***In all cases, use the definitions supplied on the COMPASS, in these instructions, the Reporting Guide, Consolidated Area Agency Reporting System (CAARS) and Client Data Systems or by this office as part of the Standard Service Definitions. Do not use definitions used on other assessment forms.*** Our ability to achieve consistency in assessment from assessor to assessor depends on a common understanding of all the terms.

HOW TO ANSWER QUESTIONS --- completing questions having ranges of responses will be easier by beginning with the first descriptor if the person is relatively independent, and the last if the person tends to be heavily dependent. ***Descriptors that are obviously not applicable to the person should be eliminated immediately.*** Attention can then be focused on the remaining descriptors to determine which best describes the individual.

USE YOUR BEST JUDGMENT --- At times it may be difficult to choose between two responses to describe a person. ***Do not leave the question blank, but use your best judgment to select the most appropriate response. It may be possible to use other available information to provide a response.***

EXAMPLES --- ***Examples given in these instructions are just that -- examples.*** They suggest types of conditions that pertain but are not to be taken as the only ones that apply.

MEASURE THE PERSON'S STATUS --- ***a person's functional status fluctuates from day to day and even within the day.*** To determine at what level a person will be assessed, use the following four CRITERIA:

- **TIME PERIOD** --- Use the person's average status over the past ***four weeks*** (unless a question specifically uses a different time period). If the assessor's information about the person covers less than four weeks, use that lesser time period in assessment of the person for the COMPASS.
- **60% RULE** --- Measure what the person generally does. Generally means ***what the person did 60% or more of the time*** during the past four weeks or appropriate time period. If the person's care plan is or will be governed by a behavior that took place less than 60% of the time, base the assessment on this behavior since it is influencing the plan of care.
- **CHANGE OF CONDITION RULE** --- If the person has improved or deteriorated during the past 28 days and is expected to remain at the new level or continue

to change in the same direction, ***record on the assessment instrument the response that best reflects the person's new functional status.***

- **MEASURE WHAT THE PERSON ACTUALLY DOES** --- Measure the person's actual performance, not what the person might be able to do. This applies even when someone else performs a task that the person can do.
- **OBSERVED VS. RECORDED** --- If a medical or other record for the person is not consistent with the person's actual functional status or the care being provided, ***use the actual rather than recorded.***
- **SHARE WITH THE PERSON BEING ASSESSED** –
 - That you want to ask some questions about themselves, because you don't want to sit there and make assumptions about them; you want to get to know them accurately. And a lot of people have identities that people can't necessarily see. Also, that you don't want to make assumptions about the kind of relationships they have, or how they see themselves. You want them to let you know, so that you can really get to know you and understand what's going on in their life.
 - Tell them that everyone gets the same questions, so no one is being singled out. Note too that medical and health information must remain private and is federally protected against intrusion and unlawful sharing under State and Federal law. [If possible, you can provide materials on the federal Privacy Rule and how medical and health information is kept private. For more information, visit www.hhs.gov/ocr/privacy/]
 - Let them know that the only people who will see this information are the case manager and that person's supervisor. If someone else needs to see your information, you will be notified. You can also say that some data is anonymously reported to the state but will not include your name or address.
 - Make it clear that the person being assessed is the primary focus of the assessment. Make every effort to understand and act on his/her point of view. At times, these instructions emphasize the involvement of appropriate family members and other informal caregivers whenever possible. However, this involvement should occur only with the consent of the person being assessed. Also, if there are differing and competing wishes, those of the older person who is being assessed should come first whenever possible.

SOURCES OF INFORMATION --- the information requested may be available from the person, informal supports, and/or available agency records (those of the completing agency and others). However, the person her/himself should be the first and primary source of information unless the person is unable to provide information.

NEED TO MAKE A REFERRAL TO A HEALTH OR MENTAL HEALTH PROFESSIONAL -- See Appendix "Indicators for Referral", at the end of the Instructions. The assessment interview provides the assessor with an opportunity to observe and

learn many things about the person. Some of these may be beyond the scope, training and/or purview of the assessor and some may require follow-up. The Appendix provides guidance in evaluating some of these conditions, in determining when to consider them to be emergencies, and in deciding on appropriate follow-up. Become familiar with the material in this appendix so that it is available during the assessment and care planning processes.

INTAKE INFORMATION

This is a stand-alone section that is completed only at the time of the initial contact.

- A. Person's Name:** Self-explanatory.
- B. Address:** Specify the person's current address. If this is temporary indicate this. Also, if any further contact will be at a different location this should be noted and the additional information provided.
- C. Phone # and E-mail:** Enter all phone numbers at which person can be reached. If this is temporary indicate this. If further contact will be at a location with a different phone number this should be noted and the additional information provided. If none, write "none". **Enter the client's e-mail address if one's available and used.**
- D. Date of Referral:** Enter the date that the referral came in to your office using two digits each for the month, day and year. For example, April 15, 1997 would be entered as 04/15/97.
- E. Referral Source:** Identify the person by name who made the referral and the agency he/she is affiliated with, if there is one (for example: Mary Smith, receptionist at Doctor Jones' office); or the connection the referrer has to the person (for example: Edith Noble, next door neighbor). Also include a phone number in case it is necessary to follow up with the person who made the referral.

If it is a self-referral, this would be so noted.
- F. Presenting Problem/Person's Concern(s):** Summarize the statements made by the referral source that explains why the referral is being made.
- G. Does The Person Know That A Referral Has Been Made?** Find out if the person is aware of the referral being made on his/her behalf and if not, why not, as this information has implications for how the assessor may approach the person in order to continue with the assessment process.
- H. Intake Worker's Name and E-mail:** Self-explanatory.

CASE IDENTIFICATION

Client Case #: This is the unique identifying number generally completed by the software system being used to meet the 10 digit client record/number key requirement.

Assessment Date: Enter the date that the assessment is being conducted using two digits each for the month, day and year. For example, April 15, 2012 would be entered as 04/15/2012.

Assessor Name: Self-explanatory.

Assessment Agency: Self-explanatory.

Reason for COMPASS Completion: Check the one item which best explains the reason for the assessment. "Initial" refers to the first assessment done for a person who has not previously been assessed for any of the community based long term care services covered by this assessment/reassessment process. "Reassessment" is an assessment done after the initial assessment or a subsequent reassessment, according to the required timeframes or because of a change in the person's situation that indicates the need to conduct a complete event-based reassessment.

Next Assessment Date: Enter the projected date for the next assessment using two digits each for the month, day and year. For example, April 15, 2013 would be entered as 04/15/2013.

I. CLIENT INFORMATION

A. Person's Name: Self-explanatory.

B. Address: Specify the person's address, *where services will be provided*. Be sure to include the zip code.

If the mailing address is different from the person's home address, this should be noted and the mailing address included in the case file.

C. E-mail: Enter the client's e-mail address if one's available and used.

D. Telephone No.: Enter all phone numbers including cell at which person can be reached. If none, write "none."

E. Social Security No.: Use only the number assigned by the federal Social Security Administration to the person, not one assigned to the person's spouse. If the person has no Social Security Number, write in "none." If a person refuses to give you this information write "refused" and continue on with the assessment. You can ask if they will provide the last four digits of the social security number. This being used for research purposes with grants provided by our Federal funding agencies.

F. Marital Status: Check the appropriate answer.

Note to interviewer: "Domestic partner" is a legal relationship recognition status available to some same-sex and opposite-sex couples in some states and cities. Some couples also may define themselves as "domestic partners" or "significant others" even if they have no legal relationship to each other. It is important to recognize that for some, the most important person in their lives is someone to whom they have no legally recognized relationship. If a client checks this category, you should consider asking the client who is the domestic partner/significant other so as to better inform your care plan for the individual. Please note that Domestic Partnership is not the same as a legally recognized marriage in New York State.

G. Sex: Self-explanatory. Check the appropriate answer.

Note to interviewer: If a client asks what you mean, you can clarify and say "when you were born, did the doctors say you were a boy or a girl?"

H. Transgender - Gender Identity or Expression ---

Note to interviewer: This question may draw some questions from your client. If the client asks what you mean, you may provide further guidance by saying, "Your gender is the way you experience yourself – for many people that's either male or female, and for some people it might be something else."

I. Birth Date: Enter the date that the person was born using two digits each for month, day and year. For example, November 4, 1923 would be entered as 11/04/1923.

Age: Self-explanatory

J. Race/Ethnicity: Self-explanatory.

K. Sexual Orientation --- Note to interviewer: If a client asks why you need to know that, you might say:

These questions, along with all the other questions you are being asked, are designed for us to get to know you better so that we can offer you the best care possible. It is important for us to understand your needs and the services we may be able to provide for you.

L. Creed: Enter the person's creed, a formal statement of religious belief; a confession of faith or a system of belief, principles using one of the available responses including did not answer or other.

M. National Origin: Enter the person's national origin which includes the birthplace of the individual or their ancestors as self-identified by the client.

N. Primary Language: Answer all parts of this question by checking the appropriate boxes. Specify the primary language if it is other than English or Spanish. ***Note that this question is designed to allow for different languages to be entered for the three language skills.***

O. Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English are considered to be limited English proficient, or "LEP." This can affect their ability to receive needed services and require the provision of interpretation services.

P. Living Arrangement: Identify who the person lives with. Check all the choices that apply. This information should be collected for the residence where the person will be receiving formal services.

Q. Has the person experienced any of the listed forms of abuse within the last six months and were they referred to one of the listed agencies. If the issues are ongoing review what steps can be taken to provide assistance.

R. Emergency Contact Person: Enter the name, address, relationship to the person, phone number(s) at home and work of the primary individual the person wishes to be contacted in case of an emergency. There is room to provide this information for a secondary emergency contact person, if two individuals have been identified. If none, print "none."

II. HOUSING STATUS

A. Type of Housing: Check the type of housing that applies.

Single Family Home: a detached living unit housing one household. Trailers/mobile homes, elder or echo cottages and accessory apartments are considered single-family homes.

Multi-unit Housing: more than one living unit such as two, three or four family dwellings, duplexes, triplexes, condominiums, cooperatives, or multi-unit apartment buildings/complexes.

If other, specify.

The assessor should describe under the Comments any special living conditions associated with the person's type of housing that affects the person's informal support system. For example, an elder cottage may be located on property containing the home of a family member, which would have a direct impact on the person's supportive environment.

B. Person Owns, Rents, Other: Check the appropriate answer. If other, specify. For example, a person may live with a family member or friend, but pay no rent.

- C. Home Safety Checklist:** Check each condition that applies. The checklist will help the assessor identify situations that may cause problems to the person's or providers' health and safety or the person's capacity to stay at home.

The following guidelines should be used to evaluate the conditions that are included in this section:

Accumulated Garbage: Assessor should check both inside and outside to determine if there is an unusual amount of accumulated garbage which may affect the person's general health and safety.

Bad Odors: These are odors which appear unusual such as strong smell of urine, rotting garbage, animal waste.

Carbon Monoxide (CO)/Detectors Not Present/Not Working:
Check/Recommend installation.

Doorway Widths Are Inadequate: When applicable to the person's situation, doorways should be wide enough to accommodate a wheelchair or other special equipment, such as a walker.

Floors and Stairways Dirty and Cluttered: Self-explanatory.

Loose Scatter Rugs Present in One or More Rooms: Self-explanatory.

No Lights in the Bathroom or in the Hallway: Self-explanatory.

No Handrails on the Stairway: Check the condition of the handrails.

No Lamp or Light Switch Within Easy Reach of Bed: Fixtures should be at a height that is comfortable and possible for the person to reach. For example, if a person is in a wheelchair, fixtures might have to be lowered or if a person is bedridden and cannot reach a wall switch, a new arrangement such as extension cords or new lights may be needed.

No Locks on Doors or Not Working: Self-explanatory.

No Grab Bar in Tub or Shower: Self-explanatory.

No Rubber Mat or Non-Slip Decals in the Tub or Shower: Self-explanatory.

Smoke Detectors Not Present/Not Working: Check Battery/ Recommend installation.

Stairs Not Lit: Check for inadequate lighting.

Stairways Not in Good Condition: Check for dirt, clutter and condition of stair treads. Stairs should be firm and strong.

Telephone and Appliance Cords Strung Across Areas Where People Walk: Self-explanatory.

Traffic Lane from the Bedroom to the Bathroom Is not Clear of Obstacles: Self-explanatory.

Other: Specify any other home environment condition that might be problematic to the person's health or safety. For example, exposed or hazardous wiring, pest or vermin infestation.

Under Comments include all changes that must be made to accommodate person's current condition. For example, a commode installed and bath arrangement made downstairs if the only house bathroom is upstairs and the person cannot climb stairs; the installation of a bed downstairs; or bed with rails because the person needs such protection at night. Include any other factors which might affect the care plan, such as availability of space for a sleep-in care giver.

- D. Neighborhood Safety:** Check yes or no. Check yes if environmental conditions outside the person's residence affect the safety of the person or of informal or formal caregivers. For example, high crime rate in the neighborhood, and describe under the Comments.

III. HEALTH STATUS

As you go through the Health Status section, keep in mind that a referral may be necessary for the person based on information provided to the assessor. Referral information is located in the Care Plan section; you should note the possible need for a referral in the comments portion at the end of this section.

- A. Primary Physician, Clinic, HMO, Hospital:**
Name/Address/Phone

Complete the Appropriate Line:

- Physician if person has an individual private practitioner as primary medical provider;
- Clinic/HMO if a clinic or HMO;
- Hospital if the person uses the emergency room as his/her primary medical provider.
- Other: specify health practitioners other than the primary provider regularly involved in the person's care, including specialists.

Print name, address, and phone number of health practitioner who monitors

person's health and provides health care services. If applicable, specify the type of primary care provider and title (e.g., doctor of medicine - M.D. ; physician assistant - P.A.; nurse practitioner - N.P., etc.)

A person may not have a physician, clinic or HMO who serves as primary provider. ***Under no circumstances may an assessor force a person to choose a particular provider, or force a person to seek a provider.*** A person without a primary medical provider should be assisted in finding one, and encouraged to do so. Depending on instructions from the local AAA, assistance in finding a primary medical provider may be the responsibility of the assessor or another staff person.

Services cannot be withheld if the person refuses to seek a primary medical provider, except if you determine that services cannot safely be provided.

B. Date of last visit to Primary Medical Provider: Note the month and year of most recent visit to primary medical provider. Specify whom the person saw on most recent visit, reason for contact, and specify location of visit in the comments portion of this section, if applicable.

C. Does the person have a self-declared chronic illness and/or disability? Check all that apply from the list provided. If the person indicates a condition not listed, check 'other' and specify. Under the Comments, include diagnoses and impairments that may affect the Care Plan. Definitions for items in the list are included at the end of the instructions for item III.C.

To answer this item, use all available sources: the person her/himself and, with the person's consent, informal caregivers, the person's physician if necessary, and informed formal service providers. The purposes of recording this information are to have available data which assist in:

- Making a Care Plan which is appropriately responsive to the person's needs;
- Enabling the assessor or other designated person to participate in the coordination of other services if necessary; and
- Identifying indicators for referral for medical assessment and/or treatment if needed.

The assessor should ask the person to describe known health conditions, and to state whether the condition has been diagnosed by a health professional and a course of treatment prescribed. Note if the person seems to have a good awareness of his/her health condition. Note especially if your observation suggests the possibility of other health conditions not named by the person.

Some persons may not have a well-organized perception of their health condition. In those cases, you may have to undertake a more focused interview with the person or by interviewing others.

Any of the health conditions may require action by the case manager, including discussing with the person what current treatment or remedy is being used or considered. Some conditions should be brought to the attention of a Nutrition Program for the Elderly as they may indicate need for assessment by a nutritionist or dietitian. These conditions are:

- alcoholism
- cancer
- dental problems
- diabetes
- digestive problems
- heart disease
- high blood pressure
- hypoglycemia
- smelling impairment
- swallowing difficulties
- taste impairment

Health Status Checklist Definitions

The purpose of these definitions is to help the assessor understand and clarify the meaning of conditions that may affect the client. If the person has a condition, indicates the possible presence of a condition, or the assessor observes the possible presence of a condition, the definitions should help the assessor clarify the condition and consider whether follow-up should be pursued.

Alcoholism: A disorder manifested by complete absorption with and loss of control over consumption of alcohol and characterized by chronicity, intoxication, and tendency toward relapse. Excessive drinking causes physical disability, leading to impaired emotional, occupational, and social adjustments.

Symptoms and Signs: There may be motor instability; reduced mental function; increased pulse rate; decreased blood pressure; dilated pupils; flushing of skin; drowsiness or stupor.

Alzheimer's Disease: A severe neurological disorder marked by progressive dementia and cerebral cortical atrophy. The disease has a relentless and irreversible course but may take from a few months to four or five years to go to the stage of complete helplessness.

Arthritis: Inflammation of a joint, usually accompanied by pain and, frequently, changes in structure.

Cancer: Any of various malignant tumors or neoplasms that manifest invasiveness and a tendency to spread (metastasize) to new sites. It spreads directly into surrounding tissues and also may be disseminated through the lymphatic and circulatory system.

Constipation: Difficult defecation; infrequent defecation with unduly hard and dry fecal material; sluggish action of the bowels.

Colitis: Inflammation of the mucus membrane of the colon.

Colostomy: Incision of the colon for the purpose of making a more or less permanent duct (fistula) between the bowel and the abdominal wall. The location is usually indicated as groin area (inguinal colostomy) or back and sides between lowest ribs and pelvis (lumbar colostomy), etc.

Congestive Heart Failure: Condition, characterized by weakness, breathlessness, abdominal discomfort, edema in lower portions of body, resulting from venous stasis and reduced outflow of blood.

Dehydration: Occurs when output of water exceeds water intake. May result from deprivation of water, excessive loss of water, reduction in total quantity of electrolytes, or injection of hypertonic solutions.

Dental Problems: Pertaining to the teeth.

Diabetes: A disorder characterized by an abnormally high concentration of glucose in the blood (hyperglycemia) and excretion of abnormal quantities of sugar in the urine (glycosuria).

Diabetes mellitus is a disease of pancreatic origin, characterized by insulin deficiency, subsequent inability to use carbohydrates, excess sugar in the blood and urine, excessive thirst, hunger and urination, weakness, emaciation, imperfect combustion of fats resulting in abnormal increase in acidity in body's fluids (acidosis), and, without injection of insulin, eventual coma and death.

Diarrhea: Frequent passage of watery bowel movements. It is a frequent symptom of gastrointestinal disturbances and is primarily the result of increased wave-like muscle contractions that propel contained matter along tubular organs (peristalsis).

Digestive Problems: Problems with digestion, the process by which food is broken down mechanically and chemically in the digestive tract and converted into absorbable forms.

Diverticulitis: Inflammation of a diverticulum or of diverticula in the intestinal tract, especially in the colon, causing stagnation of feces in little distended sacs of the colon.

Fractures (Recent): A sudden breaking of a bone, or a broken bone. A recent fracture is one that has occurred within the past two years or so.

Frequent Falls: has the person experienced 2 or more falls during the prior one year period.

Gall Bladder Disease: Any pathological disorder affecting the gall bladder and/or bile ducts.

Hearing Impairment: Difficulty perceiving sound.

Heart Disease: Any pathological disorder of the heart.

Hiatal Hernia: Protrusion of the stomach upward into the mediastinal cavity, through the esophageal hiatus of the diaphragm.

High Blood Pressure: A diagnostic judgment or opinion which must be considered with respect to the person's age, body build, previous blood pressure, and state of mental and physical health at the time the blood pressure is obtained.

High Cholesterol: Having levels of LDL (low-density lipoprotein cholesterol, also called "bad" cholesterol) in excess of 160.

Hypoglycemia: Deficiency of sugar in the blood. A condition in which glucose is abnormally low.

HIV/AIDS: A diagnoses has been made.

Liver Disease: Any of several ailments affecting the liver. The liver receives blood from the portal vein and thus is the first organ to receive blood from the intestines where the blood has absorbed the final products of digestion and decomposition products.

Low Blood Pressure: A diagnostic judgment or opinion which must be considered with respect to the person's age, body build, previous blood pressure, and state of mental and physical health at the time the blood pressure is obtained.

Osteoporosis: Increased porosity (small openings) of bone, leads to frequent fractures, falls, humpback, and/or loss of height. This frequently occurs in women due to a calcium deficiency.

Parkinson's: A chronic disease affecting the central nervous system

characterized by a fine slowly-spreading tremor, muscular weakness and rigidity.

Renal Disease: Disease of the kidney.

Respiratory Problems: Trouble with breathing.

Smelling Impairment: A decrease in the person's sense of smell. Smell and taste are closely aligned, and impairment in smell may affect ability to determine flavors, etc.

Speech Problems: Trouble with oral expressions of one's thought.

Stroke: Sudden onset of paralysis resulting from injury to brain or spinal cord.

Swallowing Difficulties: Difficulties in passing food from the mouth through the throat and esophagus into the stomach.

Taste Impairment: Difficulty determining the flavor of a substance in the mouth.

Ulcer: An open sore or lesion of the skin or mucous membrane of the body.

Urinary Tract Infection: An infection in the organs and ducts participating in secretion and elimination of urine.

Visual Impairment: Of or relating to difficulty viewing external objects.

Source: Taber's Cyclopedic Medical Dictionary (1979: F.A. Davis Company, Philadelphia) with modifications

- D. Does the person have an assistive device?** Check yes or no. If yes, check all that apply. If the person has dentures, check whether they are full or partial.

Other should be checked if assistive devices not listed are used. Examples include prosthesis, flashing lights for telephone or doorbell, telephone for persons with hearing impairments, and "grabber" to reach items on floor or overhead. Specify the device and its use where appropriate (e.g., limb which is replaced).

- E. Does the person need assistive device?** On the basis of your observations, the person's comments, or statements from the informal or formal caregivers, identify any assistive device(s) or additional assistive device(s) the person may need.

Check yes or no. If yes, specify the type of device the person needs.

- F. Does person and/or caregiver need training on use?** Check yes or no. If yes, describe the training needs or instructions required by the person and/or the informal caregiver. Specify if the person, the person and the primary caregiver, or just the primary caregiver need training on use.
- G. Has the person been hospitalized within the last 6 months?** Check yes or no. If yes, specify month/year of most recent visit. Specify the reason for stay in hospital and note month and year of discharge date.

Consider this information when developing the care plan. Service need may be affected by medical condition and should be noted. Potential referral may be necessary, depending on indicators, such as the person being frequently hospitalized.

- H. Has the person been taken to the emergency room within the last 6 months?** Check yes or no. If yes, specify month/year of most recent emergency room visit. Describe the reason for most recent ER visit and whether this led to a hospital admission.
- I. Has PRI and/or DMS-1 been completed in the past 6 months?** Check yes or no. Specify month and year of most recent assessment completed. It is possible that the person will be unfamiliar with specific names of assessment processes and instruments. The person may, however, know that a nurse or other professional has been to see her/him recently, and that she or he has been asked questions about her or his health, etc. An informal caregiver may also be helpful with this information. Find out the name of the individual and/or agency that may have performed an assessment, for further inquiry as to the specific instrument and the details such as completion date and score.

This information is valuable for several reasons. It provides additional information and insight about the person and his/her circumstances. It indicates the involvement of other professionals who you may need or want to contact at some point. It provides information that may be useful or needed in the future. Lastly, it helps the assessor in building a more complete client record.

The Patient Review Instrument (PRI) is generally performed by a nurse and is completed for purposes of nursing home placement in New York State.

A Long Term Care Placement Form (more commonly referred to as the DMS-1) is generally completed by a nurse or doctor and may have been completed for purposes of the Long Term Home Health Care Program or Program for All-Inclusive Care for the Elderly (PACE, a demonstration program operational in some locations in New York.)

Comments: The assessor should use the comments portion of this section to note any additional information about health status not covered in the

items in this section, and information based on the items that the assessor would like to specify. This is especially important as items relate to the care plan.

J. Alcoholism Screening Test - The CAGE Questionnaire

The CAGE test is a straightforward alcoholism screening test, used by many professionals in the alcohol addiction field that simplifies the process of identifying those with alcohol issues.

It is a VERY SIMPLE 4 question self-test where you have the person answer yes or no to the questions.

It is important that they note that when answering the questions they take into account their behavior and feelings over their whole lifetime NOT just now.

Let them know that just because they may have answered yes to 2 or more questions **does not mean they are alcoholic.**

What it does mean is that their drinking should be investigated further.

What do the Answers mean?

- Answering yes to 1 question.

Then the probability of an alcohol problem is about 25%

- Answering yes to 2 questions.

Then the probability of having an alcohol problem is about 50%

- Answering yes to 3 questions.

Then the probability of having an alcohol problem is about 75%

- Answering yes to 4 questions.

Then the probability of having an alcohol problem is about 95%

You can advise them that:

If you have answered yes to any of the questions in the CAGE questionnaire, or they are worried about alcohol consumption, it is strongly advisable to consult an alcohol specialist.

Usually this means making an appointment with an **alcohol/addiction counselor** and so that they can discuss their alcohol consumption with him/her.

If they feel more comfortable with their **family doctor** then they should go to them by all means. Most doctors have a good knowledge of alcoholism and its signs. If they think there is a problem they can refer to a counselor/treatment center. Medicare also now pays for screening and behavioral counseling in primary care to reduce alcohol misuse. There are no copayments, coinsurance or deductibles.

THE ASSESSOR SHOULD NOTE THE POSSIBLE NEED FOR A REFERRAL IN THIS PART OF THIS SECTION. THIS WILL BE USEFUL FOR CARE PLANNING PURPOSES.

IV: NUTRITION

Data taken in this section, together with other information on the COMPASS, will identify the need for Home Delivered Meal service and/or potential interventions by a registered dietitian.

Eligibility and/or need for Home Delivered Meal service is based on information gathered from the following sections: Health Status, Nutrition, IADLs, ADLs and Informal Support Status. This cumulative information will help the assessor in developing the person's care plan.

To be eligible for Home Delivered Meal service, the person must meet all three of the following criteria:

- Person is incapacitated due to accident, illness, or frailty; and
- Person lacks the support of family, friends, or neighbors; and
- Person is unable to prepare meals because of lack/inadequacy of facilities, inability to shop and cook for self, inability to prepare meals or lack of knowledge or skill.

Referral to a registered dietitian: Factors that should be considered include person's Body Mass Index (BMI), Nutritional Risk Score, Modified/Therapeutic Diet needs, Nutritional Supplements, and Health status.

A&B Height and Weight: Enter person's height and weight. Assessor should note the source used to document the person's height and weight. For example, the person may have been weighed measured by a health professional during his/her last doctor's visit. **Height and weight are simple but important ways of monitoring nutritional status.**

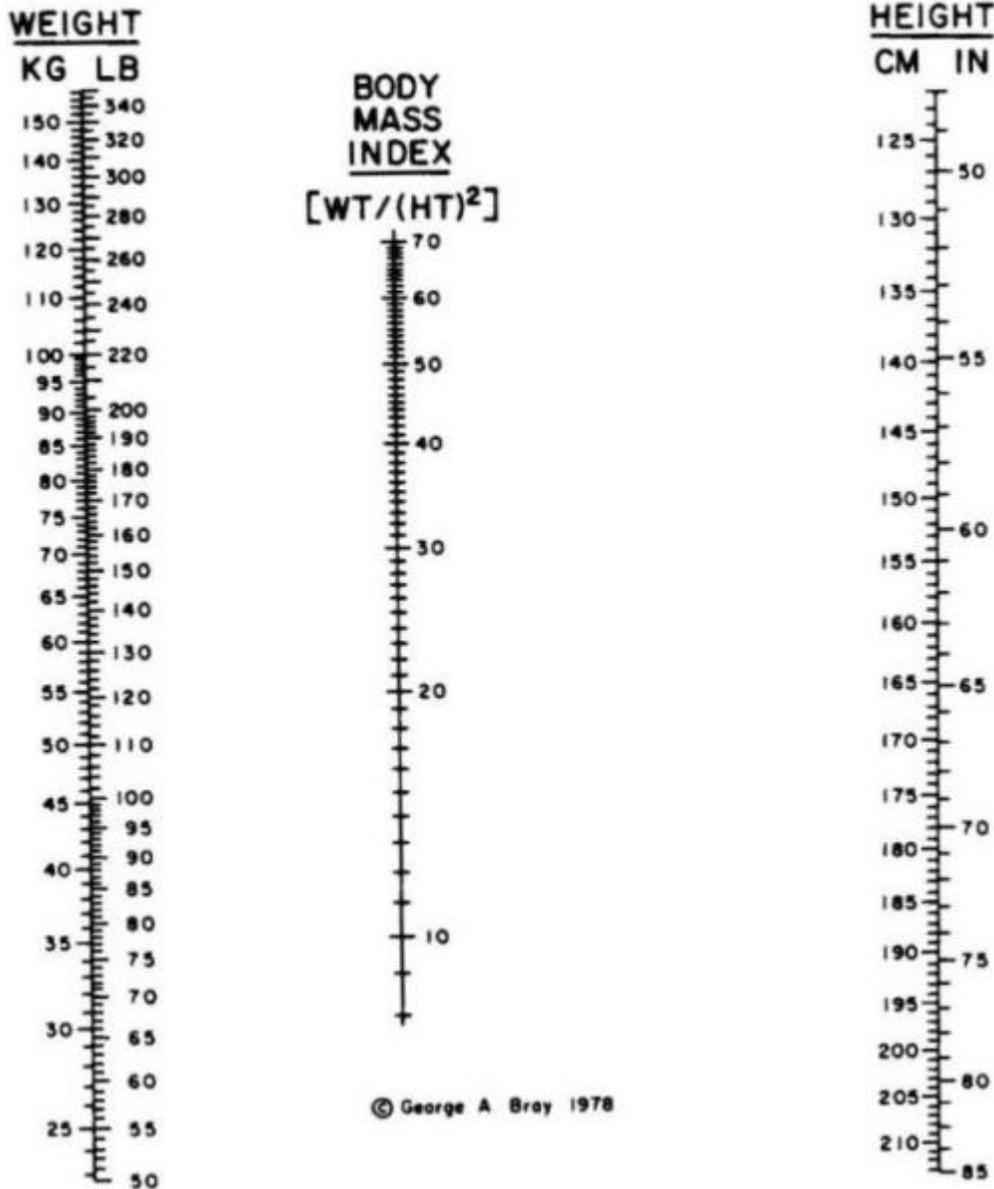
C. Body Mass Index (BMI): The BMI can be used to assess quickly whether the person is over- or underweight. Healthy older adults should have a BMI between 22 AND 27. A BMI outside of this range may indicate the need for a referral to a dietician.

BMI is calculated from the person's height (converted to inches) and weight by using the following formula: weight in pounds x 705; divide this number by height in inches; then divide this number by height in inches again. For example: Person is 5 ft. 4 inches and weighs 140 pounds. $140 \times 705 = 98,700$; $98,700 \div 64 \text{ inches} = 1542$; $1542 \div 64 \text{ inches} =$

24 (BMI). The BMI is within normal range.
Assessor may also use the Nomogram chart to calculate the person's Body Mass Index as follows:

- Record the person's height (convert into inches) and weight on the appropriate scale.
- Use a straight edge to connect the two points and circle the spot where this straight line crosses the center line.
- This is the person's Body Mass Index.

NOMOGRAM FOR BODY MASS INDEX



D. **Are the Person's Refrigerator/Freezer & Cooking Facilities Adequate?** Check yes or no. Facilities are not adequate if the person cannot safely store, cook, heat/reheat food or meals.

- E. Is the Person Able to Open Containers/Cartons & Cut Up Food?** Check yes or no. If person is unable to perform these functions, check "no". The assessor should include specific information about person's physical disability (such as arthritis, paralysis) or other reason(s) which limit the person's ability and the person's need for adaptive utensils or food containers.
- F. Does the Person Have a Physician Prescribed Modified/-Therapeutic Diet?** Check yes or no. ***Check yes only if diet has been prescribed by a physician.*** If possible, the assessor should determine if the person has a copy of his/her prescribed diet.

A modified/therapeutic diet is designed to meet the requirements of a given situation. It may be modified in individual nutrients, caloric value, consistency, flavor, content of specific foods or a combination of these factors.

If yes, check which type of modified/therapeutic diet the person's physician has prescribed. Types of modified/therapeutic diets include the following:

Texture Modified: A diet designed to minimize the amount of chewing or aid in swallowing. It may be used for dental problems, postoperative patients of head, neck, and mouth surgery, and stroke. For example: chopped diet.

Sodium Restricted: The goal of sodium (Na, salt) restriction is to control hypertension, promote the loss of excess fluids and/or manage impaired liver function, cardiovascular disease and renal disease. Foods containing large amounts of natural sodium or commercially processed foods to which sodium has been added are restricted in amount (e.g., salted snack foods, sauerkraut, seasoning salts.) For example: No Added Salt diet, 2 gm. Sodium.

High Calorie, High Protein: A diet designed to meet the need for increased nutrition during certain illnesses such as cancer and HIV. Nutritional supplements may be included as part of an overall nutritional care plan.

Calorie Controlled Diet: The goal is to aid in the management of Diabetes and/or in weight control. In cases of Diabetes, daily dietary intake is controlled carefully for calories, protein, carbohydrates, and fat. Diet may require simple menu substitutions such as in desserts high in concentrated sugar: cakes, cookies, pies, canned fruit in heavy syrup. For example: 1200 ADA calorie diet, or 1200 calorie weight reducing diet.

Fat Restricted: A diet designed to limit fat intake and/or reduce fat in the

blood (serum lipid levels). These lipids include cholesterol and triglycerides. A fat controlled diet is used in the management of conditions where fat is not tolerated (hyperlipo-proteinemias or for biliary tract, pancreas, and malabsorptive syndromes). For example: 40 gm Fat.

Renal: A diet designed to maintain optimal nutritional status in persons with impaired renal function who may be on hemodialysis. Protein, sodium, potassium, phosphorus, and fluid are controlled.

Other: If the person has a physician-prescribed diet that is not included in the list of Modified/Therapeutic Diets, assessor should check other and specify.

If no, ask if the person follows a regular diet or a special diet. A regular diet is designed to maintain a healthy person in a nutritional status sufficient to meet the needs of a particular stage of a life cycle. It satisfies the requirements of the recommended dietary allowances. A special diet includes or substitutes foods to meet a particular need or choice. Check all diets which apply. Types of Special Diets include the following:

Ethnic/Religious: A regular or modified diet that also considers preferences of a nationality, race, ethnic group and/or religious community. If a client has an ethnic/religious diet specify. For example: Kosher/Jewish.

Vegetarian: There are three major classifications within the term vegetarian diet: plant foods with dairy products and eggs (lacto-ovovegetarian), plant foods with dairy products (lactovegetarian), and plant foods only (vegan).

- G. Does the Person Have a Physician-Diagnosed Food Allergy?** Check yes or no. Check yes ***only if allergy has been diagnosed by physician.*** Allergies produce definable physiological reactions, including but not limited to indigestion, diarrhea, hives, intestinal cramps, and choking. ***Do not enter food dislikes.*** If yes, describe which food produces an allergic reaction.
- H. Does the Person Use Nutritional Supplements?** Check yes or no. If person uses food or beverage supplements, including vitamin/mineral supplements, answer yes. If yes, specify who prescribed and describe the type of supplement(s) person is currently taking.
- I. Nutritional Risk Status (NSI):** The purpose of questions in this section is to determine the person's Nutritional Risk Status based on the person's responses.

The person's nutritional risk score will help the assessor make appropriate referrals to a registered dietitian.

Check all appropriate risk indicators that apply and circle corresponding numbers at the right. All "yes" answers have a score assigned. The NSI score is obtained by adding the number of those factors that were answered yes. Check the appropriate level of nutritional risk.

Score of 6 or more indicates "high" nutritional risk: Refer to registered dietitian

Score of 3-5 indicates "moderate" nutritional risk

Score of 2 or less indicates "low" nutritional risk

1. **Person Has Illness or Condition that Changes the Kind and/or Amount of Food Eaten:** Any disease, illness or chronic condition may affect the way a person eats. Also confusion, memory loss, loneliness, or depression can cause changes in a person's appetite and/or digestion. Energy level may have an effect. The assessor may want to cross reference the person's response to this question with Section III. Health Status, Item C and Section V. Psycho-Social Status, Item A.
2. **Eats Fewer than Two Meals/Day:** Self-explanatory.
3. **Eats Fewer than Two Daily Servings of the Following Food Groups:** A serving from each food group constitutes the following:
 - Fruits:** One half cup cooked, fresh or juice; or portion as normally served.
 - Vegetables:** One half cup cooked or fresh; or portion as normally served.
 - Milk Products:** One cup of milk or yogurt, one ounce of cheese, one half cup of ice cream or cottage cheese.

If person answers yes to any of these, circle the 2 points. For example, if a person eats fewer than two daily servings from fruits, vegetables, and milk products, you would **add only 2 points**. If the person eats fewer than two daily servings from the fruit group, but indicates he/she is eating more than two daily servings from vegetable or milk group, you would still **add only 2 points**.
4. **Has Three or More Drinks of Beer, Liquor or Wine Almost Every Day:** Self-explanatory.
5. **Has Tooth or Mouth Problems that Make It Hard to Eat:** Refers to problems person may have with loose, missing, or rotten teeth, poor gums, or dentures which don't fit well or cause mouth sores making it hard to eat.

6. **Does Not Always Have Enough Money to Buy Food that Is Needed:** Self-explanatory.
7. **Eats Alone Most of the Time:** Self-explanatory.
8. **Takes Three or More Prescribed or Over-the-Counter Drugs a Day:** *This question should be asked and cross-referenced with Section VIII-Medications currently taken.*
9. **Without Wanting To, Lost or Gained 10 Pounds in the Past Six Months:** Self-explanatory.
10. **Not Always Physically Able to Shop, Cook and/or Feed Self:** Self-explanatory.

Comments: Specify any special considerations which have been noted in the Nutrition Section or elsewhere on the COMPASS and that have an impact on the person's nutritional needs or indicates the need for a referral to a dietitian. These include:

- Health related factors (Section III, item C): The assessor should be aware that the majority of health conditions listed there have implications for nutrition intervention.
- Impaired in IADLs (Section VII): Shopping (item B); Prepare and Cook meals (item E)
- Impaired in ADLs (Section VIII): Mobility (item D); Eating (item G).
- Informal Support Status (Section X).

V. PSYCHO-SOCIAL STATUS

For each of the questions, assess the presence of the behavior as exhibited by the person, or reported by his/her formal and/or informal caregivers.

Your capacity to provide details in response to these questions will depend not only on your interviewing skills but also the amount of experience you have with the person and his/her formal and/or informal caregivers. When the behavior or condition exists, describe to the extent possible in the space provided. The person's psycho-social status must be considered during the development of the Care Plan. Insofar as you can, any comments you make concerning a problem behavior should include the following factors:

Frequency: How often does this behavior occur? Describe the behavior as occurring monthly if it happens one to three times every four weeks; weekly if it happens at least weekly but not daily; and daily if it happens every day.

Predictability: Is the behavior predictable or unpredictable? For predictable behavior, the caregiver can discern when a person will exhibit the behavioral problem and plan appropriate responses in advance. The behavioral problem

may occur during ADL routines (e.g., bathing), specific treatments (e.g., ambulation exercises) or for a logical reason, such as being wrongly criticized, bumped into, etc. The behavior is unpredictable when the caregiver cannot foretell when or under what circumstances the person will exhibit the behavioral problem since there is no evident pattern.

Origin of Condition: When measuring the person's condition, do not consider the origin of this disability, i.e., physical, mental and/or social problems. The concern for measurement is what the person's condition is. Origin of condition is not relevant to the assessment:

A. **Does the Person Appear, Demonstrate and/or Report, Any of the Following? Check all that apply.**

Checklist Definitions

Alert: The person is mentally responsive and perceptive. Able to appropriately communicate and provide feedback.

Cooperative: The person willingly works with others that are acting on his/her behalf.

Dementia: The person demonstrates distorted comprehension and expression. Exhibits inaccurate or unwise decision making and unsafe self-direction.

Depressed: The person appears melancholy and/or withdrawn. Expresses feelings of sadness and/or guilt. For example, the person often refuses to participate in social activities.

Disruptive Socially: Through verbal and/or physical actions, the person interferes with others. This interference requires immediate attention to control the situation. Without intervention, the disruption would persist or a problem would occur.

Hallucinations: The person demonstrates false or distorted perception of objects or events with a compelling sense of their reality. For example, the person may claim to see people or objects that are not there.

Hoarding: Pathological or compulsive hoarding is a specific type of behavior characterized by:

- acquiring and failing to throw out a large number of items that would appear to have little or no value to others (e.g., papers, notes, flyers, newspapers, clothes)
- severe cluttering of the person's home so that it is no longer able to function as a viable living space
- significant distress or impairment of work or social life

Impaired Decision-Making: The person makes decisions which put

themselves and/or others at risk of illness, injury, and/or death. The person creates financial risk due to inappropriate expenditures. This is not due to lack of knowledge.

Lonely: The person expresses feelings of loneliness. States for example, that he/she does not see his/her family and friends enough and/or indicates that he/she misses contact with other people.

Memory Deficit: The person demonstrates forgetful behavior which is dangerous to self or others. For example, fails to shut off burners on stove, fails to put out cigarettes, does not watch food that is cooking and/or burns food, etc.

Physical Aggression: The person is assaultive or combative to self or others with intent for injury. For example, the person hits self, throws objects, punches or hits others, and/or makes dangerous maneuvers with wheelchair.

Self-Neglect: is a behavioral condition in which an individual neglects to attend to their basic needs, such as personal hygiene, appropriate clothing, feeding, or tending appropriately to any medical conditions they have. Extreme self-neglect can be known as Diogenes syndrome.

Sleeping Problems: The person exhibits increased activity, restlessness, anxiety, fear, and/or tension that occurs during the night.

Suicidal Thoughts: The person expresses feelings of despondency, self-destruction or suicide. For example, the person states he/she would like to end it all.

Suicidal Behavior: The term is understood to mean both suicidal equivalents not recognized as such (accidents, repeated risk-taking) and repeated suicide attempts whose chronic and unsuccessful nature certainly constitutes a real risk, but which are also acts of essentially relational significance.

Verbal Disruption: The person routinely yells, baits, and/or threatens other individuals.

Worried or Anxious: The person appears uneasy, distressed and/or troubled. Demonstrates apprehension, fear, nervousness and/or agitation.

Other (specify): Do not include behaviors or conditions otherwise noted in this section or elsewhere on the COMPASS. Indicate behaviors not included on the list that may affect the safety of the person and/or caregivers. In the space provided, enter the problem behavior.

B. Evidence of Substance Abuse Problems: Check yes or no. If the person

demonstrates behaviors such as abuse of drugs and/or alcohol (there are clear patterns, levels and strength of the evidence that indicate such abuse), check yes and describe in the space provided.

- C: Problem Behavior Reported:** Check yes or no. Although not demonstrated during your observations and/or through your interactions directly with the person, check yes, if the person's formal and/or informal caregivers report problem behavior. This situation will require further investigation and assessment to verify. Describe in the space provided.
- D. Diagnosed Mental Health Problem:** Check yes or no. If the person has a professionally diagnosed mental health problem and/or an active treatment plan, check yes and describe in the space provided.
- E. History of Mental Health Treatment:** Check yes or no. If the person has a history of receiving professional services or any other type service for a mental health condition, but not now receiving such services, check yes and describe in the space provided.
- F. Does It Appear That A Mental Health Evaluation Is Needed?** Check yes or no. On the basis of a past mental health assessment and the observation of current behavior problems, the person should be referred to treatment services. The services can be provided in any appropriate setting. **Note Section E, Problems to be referred, in the Care Plan Section, XIII.** Also see Appendix, Indicators for Referral.

VI. PRESCRIBED AND OVER THE COUNTER MEDICATIONS CURRENTLY TAKEN

In care planning, medication use patterns may need to be addressed. You should assess potential problems in drug use, such as history of non-compliance or abuse of specific medications or with all medications. Observe indicators for possible problem behaviors, such as use of outdated medications, similar medications from several physicians, and use of medications (over-the-counter and prescription) which may be antagonistic or which may exaggerate each other's effects. For example, use of aspirin and blood thinners (anti-coagulants).

A. Medications: Name, Dose, Frequency, Reason Taken

Determine medications used and purposes as stated by the person or by another informed source. A useful technique in the home is to ask to see containers of all medications used. If assessor believes there is a problem, you should check with person's pharmacist or physician (if person has one).

Name: List all medications that are prescribed and/or purchased over-the-counter. Medications include laxatives, antacids, heart

medication, etc.

Dose/Frequency: For each medication listed, identify the amount/quantity to be taken at each time (e.g., three teaspoons, 1 250 mg tablet). Also state the frequency which is the number of times the medication is to be taken per day, week or as needed.

Reason Taken: State the reason for taking the medication as expressed by the person. Record the person's statement of the reason for taking the medication. To the extent possible, you should attempt to have an explanation provided to the person when she/he cannot remember the reason for the medication, or if the reason does not match your personal understanding of the purpose of the medication. It is important to note if the person is not taking medications properly (knowingly or unknowingly.)

- B. Primary Pharmacy and Phone Number:** Specify the name and phone number of the primary pharmacy used by the person for prescriptions and other drug/personal items. This should be asked of the person and may be confirmed by the labels on the prescription medication.
- C. Does the Person State Any Problems With Medication(s)?**

Adverse Reactions/Allergies/Sensitivities:

Check yes or no. If yes, describe any demonstrable physiological reactions produced by any substance. Include substances that cause an allergy (allergens) such as medications and/or environmental factors. Food allergies should **not** be included here, as they are recorded in Section VI., Nutrition.

Cost of Medication

Check yes or no. If yes, describe any problem the person states that he/she has with cost of medication. This is important for potential referral.

Obtaining Medications

Check yes or no. If yes, briefly explain whether person can get own medications (refill prescriptions), whether it can be done by an informal caregiver, whether pharmacy can deliver, or whether a formal service is needed to obtain medications. This may be important for care planning.

Other: Self-explanatory.

VII. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLS)

Use the following qualifiers in answering each IADL question:

Time period: Past four weeks.

Frequency: Assess how the person completed each IADL 60% or more of time it was performed (***IADL status may fluctuate during the day or over the past four weeks***).

Changed Condition Rule: When a person's capacity to perform IADLs with or without an adaptive/assistive device has improved or deteriorated during the past four weeks and this course is unlikely to change, measure the IADL according to its status during the past seven days.

Changes in Functional Capacity: Consider whether the degree to which the person can no longer perform the activity is a temporary condition or whether it is longer term. For example, a person might need total assistance with shopping because he/she is recovering from an operation or broken limb, but the level of assistance would diminish as the person recovers. Indicate whether the current situation is temporary and, if so, how much the person can be trained to perform the IADL, or how much the person will improve. Indicate if the person's functional capacity is expected to decline over time. The goal is to allow the person to be as independent as possible.

Activity Status: What Can the Person Do? The IADLs are those basic functions that people must be able to do to take care of themselves on a daily basis. They involve handling equipment, tools or systems outside the body. Consider the person's abilities such as bending, stretching, lifting, pulling, walking a specific distance, etc. By breaking tasks into simple steps, the assessor will be able to determine what aspects of each task are most challenging. For each IADL question, four functional levels are provided to choose from. Select the most accurate level and enter its number to the right of the IADL in the box provided.

Check if Assistance Is/Will be Provided by Informal and/or Formal Supports:

If the person is not able to complete any specific activity alone, carefully consider whether the help that is required can be that of a family member or friend (Informal Supports) and/or needs to be that of a professional or a service from an agency (Formal Services). A formal service might only be necessary at the beginning to train either the person or the informal caregiver, such as in the administration of medications, or it might be needed on an ongoing basis to monitor or deliver the care. Check either or both boxes for the source of assistance to the person, as applicable.

Assess carefully if the care can be done by an informal caregiver rather than a formal service. State the name of the informal caregiver and the specific days/hours the assistance is required. However, if the person has no informal supports or if the informal supports cannot supply all the assistance needed, specify the help required from formal services. If a formal service or professional is required, be sure to state the specific reason, i.e., "to train the person," "to monitor the activity," and/or "to perform the task," and indicate the specific hours needed.

Comments: Describe any specific limitations or needs there might be for each activity, parts of tasks to be done and responsibilities of informal and formal services, and/or other factors that may be important for developing and/or implementing the Care Plan. For example, in the activity of shopping, you have the opportunity to indicate to what degree the person needs assistance. In the example of telephone, you can assess whether the person needs some type of assistive device, perhaps even the telephone itself, to satisfy the IADL need. You may organize the comments in any way that is convenient and clear for you and your supervisors. You may enter information on a task-by-task basis or you may enter information on a group of tasks together.

Definitions of Activities

A. Housework/Cleaning: To be able to dust, sweep, wash dishes, vacuum, move small pieces of furniture to clean, rinse out bath---to handle the normal range of housekeeping chores.

Status #1: Able to perform almost all household tasks --- light and heavy work. Person is totally able.

Status #2: Able to perform light housework (e.g., dusting, dishes, trash disposal). Cannot do most heavy housework (e.g., vacuuming, washing floors, cleaning kitchen). Person needs some assistance.

Status #3: Unable to do any housework. Person needs maximum assistance.

Status #4: Does not perform the activity due to unwillingness.

B. Shopping: To select, order, or purchase items in a store (groceries, clothes, drugs, etc.) and to carry them home or be able to have them sent.

Status #1: Able to go by self to shop, including carrying packages. Person is totally able.

Status #2: Person needs some assistance. Specify degree of assistance required:

- Able to go by self to shop or order items, but needs someone to carry packages.
- Able to do by self only light shopping and carry small packages, but needs someone to do occasional major shopping.
- Unable to go shopping alone, but can go with someone to assist.

Status #3: Needs someone to do all shopping and errands. Person needs maximum assistance.

Status #4: Does not perform the activity due to unwillingness.

- C. Laundry:** To carry laundry to and from washing machine, to get to laundry facilities, to use washer and dryer, to wash small items by hand.

Status #1: Able to take care of all laundry and can get to laundry facilities. Person is totally able.

Status #2: Able to do light laundry, such as minor hand wash or light washer loads. Needs help with heavy laundry such as getting to laundry facility, carrying large loads of laundry, or supervision. Person needs some assistance.

Status #3: Unable to do any laundry physically or needs continual supervision and assistance (if confused or judgment impaired). Person needs maximum assistance.

Status #4: Does not perform the activity due to unwillingness.

- D. Transportation:** Ability to use transportation such as a car, van, taxi, or public transportation to go to a place farther than person can walk. For example, to go to a medical appointment. To do this, it implies that the person has the cognitive and physical ability to travel.

Status #1: Able to drive a car or arrange and use a van, taxi or public transportation. Person is totally able.

Status #2: Person needs some assistance. Specify degree of assistance required:

- Can arrange necessary transportation, but needs help in and out of vehicle.
- Must have someone else arrange for and provide the transportation, person can use transportation.
- Does not have access to transportation --- appropriate mode of transportation unavailable.

Status #3: Person needs maximum assistance. Specify degree of assistance required:

- Person can not leave home.
- Person requires maximum assistance to arrange, help in and out of the vehicle and provide the transportation.

Status #4: Does not perform the activity due to unwillingness.

- E. Prepare and Cook Meals:** To be able to chop, cut, measure foods to prepare a recipe, to know how long food should cook to be edible. Person is able to use the stove or oven, be able to lift and move pots and pans, be able to boil water, etc.

Status #1: Able to plan and prepare all meals for self. Person is totally able.

Status #2: Person needs some assistance. Specify degree of assistance required:

- Able to fix main meals but not on a regular basis.
- Able to fix light meals (e.g., cereal, sandwich) or reheat but not on a regular basis.

Status #3: Unable to prepare any meals, even reheat. Person needs maximum assistance.

Status #4: Does not perform the activity due to unwillingness.

- F. Self-Administration of Medications:** To be able to perform all tasks involved with the use of medications, whether prescribed or over the counter. Includes tasks such as being able to follow the schedule for taking medications, identifying container having proper medication, opening the container, counting out or measuring the medication, doing any procedures to prepare the medication for use, and the acts of ingesting, applying or injecting the medication.

Status #1: Able to self-administer medication without any assistance or supervision. Person is totally able.

Status #2: Person needs some assistance. Specify degree of assistance required:

- Requires supervision to keep track of which medications must be taken, or to take medications at the proper time. Otherwise capable of taking medication as directed by others.
- Requires assistance in identifying the proper medication, opening the container, counting out pills or preparing for applying, ingesting or injecting medications; otherwise capable of taking medication prepared by others.

Status #3: Totally incapable of managing self- administration of medication, and completely dependent on others for supervision and assistance.

Status #4: Does not perform the activity due to unwillingness.

- G. Handle Personal Business/Finances:** To understand how to pay bills;

balance a checkbook; keep accounts; answer correspondence; write and keep track of when to pay which bills; handle money, understand the cost of items and count change.

Status #1: Able to pay bills (on time and for correct amount), balance checkbook/handle bank account and make contracts independently. Person is totally able.

Status #2: Person needs some assistance. Specify degree of assistance required:

- May need to be reminded to pay bills or take care of other personal business.
- May need assistance in getting materials needed (e.g., checkbook, stamps) or assistance in writing checks, letters, and balancing checkbook.
- May need assistance or guidance in handling financial matters (home mortgage, investments).

Status #3: Needs someone to write checks, pay bills and handle personal business. Person does not participate in decisions. Person needs maximum assistance.

Status #4: Does not perform the activity due to unwillingness.

H. Telephone: To be able to use phone book or know numbers of parties desired to be reached, or to actually be able to dial and use telephone regardless if person has a telephone.

Status #1: Able to look up phone numbers, dial number and receive phone calls. Person is totally able.

Status #2: Person needs some assistance. Specify degree of assistance required:

- Able to use the phone as needed, but needs some help to get to the phone.
- Able to use phone with assistance and/or supervision (look up numbers, dialing).

Status #3: Unable to use phone. Person needs maximum assistance.

Status #4: Does not perform the activity due to unwillingness.

Are changes in IADL functional capacity expected in the next 6 months?
Self-explanatory.

VIII: ACTIVITIES OF DAILY LIVING (ADLS)

Use the following qualifiers in answering each ADL question:

Time period: Past four weeks.

Frequency: Assess how the person completed each ADL, with or without an adaptive/assistive device, 60% or more of time it was performed (ADL status may fluctuate during the day or over the past four weeks).

Changed Condition Rule: When a person's capacity to perform ADLs has improved or deteriorated during the past four weeks and this course is unlikely to change, measure the ADL according to its status during the past seven days.

Changes in Functional Capacity: Consider whether the degree to which the person can no longer do the activity is a temporary condition or whether it is longer term. For example, a person might need total assistance with bathing because he/she is recovering from an operation or broken limb, but the level of assistance may diminish as the person recovers. Indicate whether the current situation is temporary and, if so, how much the person can be trained to perform the ADL, or the person will improve. Indicate if the person's functional capacity is expected to decline over time. The goal is to allow the person to be as independent as possible.

Activity Status: What Can the Person Do? The ADLs are those basic functions that people must be able to do to take care of themselves on a daily basis. For each ADL question, four functional levels are provided to choose from. Select the most accurate level and enter its number to the right of the ADL in the box provided.

Check if Assistance Is/Will be Provided by Informal and/or Formal Supports:

If the person is not able to complete any specific activity alone, carefully consider whether the help that is required can be that of a family member or friend (Informal Supports) and/or needs to be that of a professional or a service from an agency (Formal Services). A formal service might only be necessary at the beginning to train either the person or the informal caregiver or it might be needed on an ongoing basis to monitor or deliver the care. Check either or both boxes for the source of assistance to the person, as applicable.

Assess carefully if the care can be done by an informal caregiver rather than a formal service. However, if the person has no informal supports or if the informal supports cannot supply all the assistance needed, specify the help required from formal services. State the name of the informal caregiver and the specific days/hours the person is required. If a formal service or professional is required, be sure to state the specific reason, i.e., "to train the person," "to monitor the activity," and/or "to perform the task," and indicate the specific hours needed.

Comments: Describe any specific limitations or needs there might be for each

activity, parts of tasks to be done and responsibilities of informal and formal services and/or any other factor important for developing and/or implementing the Care Plan. You may organize the comments in any way that is convenient and clear for you and your supervisors. You may enter information on a task-by-task basis or you may enter information on a group of tasks together.

General Definitions:

- A. Intermittent:** A caregiver (informal or formal) does not have to be present during the entire activity.
- B. Supervision:** Verbal encouragement and observation, not physical hands-on care, is needed by the person.
- C. Assistance:** Physical hands-on care is needed by the person.
- D. Continual:** One to one care is needed by the person; if a provider is not present the person will not complete the activity.

Definitions of Activities

- A. Bathing:** To wash the body or body parts, whether tub, shower, or basin, including getting to the bath, obtaining the bath water, and getting into the tub or shower.

Status #1: Requires no human supervision or support. May use adaptive equipment.

Status #2: Requires intermittent checking and observing. May require assistance for minor parts of the task, such as transferring in and out of the bath and bathing back and feet.

Status #3: Requires continual help (supervision or physical assistance) with most parts of bathing.

Status #4: Person does not participate. Person is bathed in bath, shower or bed by another.

- B. Personal Hygiene:** Grooming, including combing hair, washing face, shaving and brushing teeth.

Status #1: Responsible for self, and receives no human supervision or assistance with personal grooming.

Status #2: Requires intermittent verbal cuing or observation, and/or requires assistance with difficult parts of grooming.

Status #3: Requires continual help (supervision and/or physical assistance)

with most or all of personal grooming.

Status #4: Person does not participate; another person performs all aspects of personal hygiene.

- C. Dressing:** Putting on, fastening and taking off all items of clothing (including braces or artificial limbs worn daily) and obtaining and replacing these items in their usual storage places.

Status #1: Needs no human supervision or physical assistance.

Status #2: May need intermittent supervision (verbal encouragement and/or minimal physical assistance) for the proper arrangement and retrieval of clothing.

Status #3: Requires continual help (encouragement, teaching, and/or physical assistance) with difficult parts of dressing.

Status #4: Specify degree of assistance required:

- Has to be completely dressed by another: person does not participate.
- Bed gown is generally worn due to condition of person.

- D. Mobility:** How the person moves about from place to place with adaptive equipment, wheelchair, or by self.

Status #1: Walks with no supervision or human assistance. May require mechanical device (for example, a walker) but not a wheelchair.

Status #2: Walks with intermittent supervision (that is, verbal cuing and observation.) May require human assistance for difficult parts of walking (for example, negotiating stairs or ramps.)

Status #3: Walks with constant one-to-one supervision and/or constant physical assistance.

Status #4: Specify degree of assistance required:

- Wheels with no supervision or assistance, except for difficult maneuvers (for example, using elevator or wheeling over ramps.) May actually be able to walk, but generally does not move.
- Is wheeled, chairfast or bedfast. Relies on someone else to move about, if at all.

- E. Transfer:** Moving between the bed and chair, getting in and out of bed or

a chair or wheelchair.

Status #1: Requires no supervision or physical assistance to complete necessary transfers. May use equipment such as railings or a trapeze.

Status #2: Requires intermittent supervision (that is, verbal cuing/guidance) and/or physical assistance for difficult maneuvers only.

Status #3: Requires one person to provide constant guidance, steadiness and/or physical assistance. Person participates in transfer.

Status #4: Specify degree of assistance required:

- Requires lifting equipment and at least one person to provide constant supervision and/or physically lift.
- Cannot transfer and is not taken out of bed.

F. Toileting: Getting to and from the toilet, transferring on and off the toilet (commode, bedpan), cleaning self after elimination, adjusting clothing, and continence.

Status #1: Requires no supervision or physical assistance. May require special equipment, such as a raised toilet or grab bars.

Status #2: Requires intermittent supervision for safety or encouragement, or minor physical assistance (for example, clothes adjustment or washing hands.)

Status #3: Requires constant supervision and/or physical assistance with major/all parts of task, including appliances (for example, colostomy, ileostomy, or urinary catheter.) Continent of bowel and bladder.

Status #4: Incontinent of bowel and/or bladder, whether or not taken to a toilet. (Incontinent: 60% or more of the time the person loses control of his/her bowel or bladder functions with or without equipment.)

G. Eating: Getting food by any means from the receptacle (plate, cup, etc.) into the body and to swallow the food served.

Status #1: Feeds self without supervision or physical assistance. May use adaptive equipment.

Status #2: Requires intermittent supervision (that is, verbal

encouragement/guidance) and/or minimal physical assistance with minor parts of eating, such as cutting food, buttering bread, or opening milk carton.

Status #3: Requires continual help (encouragement, teaching, physical assistance) with eating or meal will not be completed.

Status #4: Specify degree of assistance required:

- Totally fed by hand. Person does not manually participate.
- Tube or parenteral feeding for primary intake of food, not just for supplemental nourishments.

Are Changes in ADL Functional Capacity Expected in the Next 6 Months?
Self-explanatory.

IX. SERVICES CLIENT CURRENTLY IS RECEIVING

Check all formal services currently being provided. Indicate provider name, address, telephone number and contact person. Exclude assistance provided by informal caregivers as this information is recorded elsewhere.

X. INFORMAL SUPPORT STATUS

Unless otherwise stated, the questions in this section apply to the entire informal support system. Several questions in this section assess the capacity and needs of the informal caregivers. When possible they should be directed to both the informal caregiver(s) and the person during the assessment interview(s). When this is not possible, the question(s) should be directed to the person and the responses recorded. The assessor should contact the informal caregiver(s) directly, but only after receiving the person's permission to do so, to verify the information and get additional information as may be necessary. If permission is denied by the person, then contact should not be made with the informal caregivers that have been identified.

Space has been provided to record information for two (primary and secondary) informal caregivers if appropriate.

A. Does the Person Have Family, Friends and/or Neighbors That Could Help with Care? Check yes or no as appropriate.

*If no informal supports are present, **skip to question D.** Of this section.*

1&2 Primary and Secondary Informal Supports: Identify those who provide care for the person. Include their name, address, relationship to the person, **email addresses** and telephone number(s). Under "involvement", include the specific types of assistance and tasks, and specify the times

they are done.

For each informal support noted, check the following questions.

- a. **Does the Person Appear to Have a Good Relationship with This Person?** Check yes or no as appropriate. Clarify the response in the space provided. Do not "lead" the person to a particular answer; however, it may be necessary to help the person describe the relationship by asking probing questions or giving examples. ***For example: you might ask questions like -- How are things between you and your daughter? When you speak to your daughter what are the kinds of things you talk about -- Does she talk things over with you?***
 - b. **Would the Person Accept Help or More Help from this Person to Stay at Home and/or Maintain Independence?** Check the appropriate answer based on the information provided. Ascertain from the person to what extent she/he is willing to accept help from informal supports. It may help to provide examples. Listen to what is said as well as how things are said. Assessor observations and comments should be carefully noted as such and distinguished from what the person says. Explain in the space provided.
 - c. **Are There Any Factors that May Limit this Person's Involvement?** Check all of the appropriate answers based on the information provided. Ask this question in a neutral and understanding manner. ***For example: Are there other things that take a lot of your daughter's attention, or that make it hard for her to see you more often?***
 - d. **Would this person be considered to be a care giver?** A caregiver is a traditional or non-traditional family member, friend or neighbor who is helping another person they are concerned about with the everyday tasks of living. The caregiver and care receiver may live together, near each other or far away from one another.
- B. Is Relief Needed for the Informal Support(s)?** Check yes or no as appropriate. If yes, explain and specify when and what type of help is needed in the space provided. Explore this question in full so that the needs of the informal support system can be considered and where possible addressed during care planning.
- C. Can Other Informal Supports Provide Temporary Care to Relieve the Caregiver(s)?** Check yes or no as appropriate. If yes, include the detail in the space provided to explain who might be available, when they might be available and what they may be able to do. Before considering the options available in the formal system, review the capacity of the person's

family, friends and neighbors to determine their potential for providing a break to the primary informal supports. ***Additional follow up with these other individuals may be necessary to further explore their capacity.***

- D. Does the Person Have Any Community/Neighborhood/ Religious Affiliations that Could Provide Assistance?** Check yes or no as appropriate. If yes, provide the necessary detail in the space provided. Before exploring the options that are available in the formal system, seek out all low cost/no cost options for addressing the person's needs. Since various organizations sometimes provide community services, explore what might be available in the community.

XI. MONTHLY INCOME

The information requested in this section pertains to the monthly income of the person only. ***Do not include spouse's income, or the income of anyone else in the household.*** This information will help the assessor in determining the person's appropriateness for benefit and entitlement programs, such as those found in the next section. A person is under no obligation to disclose income information. However, if during care planning, EISEP or CSE EISEP-like services are identified as needed services, the person who refuses to disclose financial information will be required to pay the full cost of services in order to receive these services.

- A. Monthly Income:** Determine the monthly amount received by the person from each source of income. Use the net income, after expenses incurred in producing the income, --- as well as after federal, state and local income taxes --- have been deducted. Net income cannot be less than \$0.00. Be sure to use the most up-to-date income information that is available.
1. **Social Security (net):** The person's monthly income from Social Security. Enter the net amount, which is the amount after the Medicare Part B premium has been deducted.
 2. **Supplemental Security Income: (SSI)** The person's amount of SSI received each month. If the person receives SSI, he/she is automatically Medicaid certified. If the person has not received a Medicaid card, contact LDSS. If the person receiving SSI needs Personal Care, refer him/her to the Local Department of Social Services (LDSS) for Personal Care.
 3. **Pension/Retirement Income:** The amount of the person's pension/retirement benefit each month. The sources may be from private/government pensions, veteran's benefits, annuities, IRAs, etc.
 4. **Interest:** The amount of interest the person regularly receives each month from monies held in accounts such as savings, checking,

Certificates of Deposit, etc.

5. **Dividends:** The amount of money received each month from stocks, bonds, and other sources.

6. **Salary/Wages:** The monthly income the person derives from employment.

7. **Other:**

Other income must include any:

- net income from farm and non-farm self employment,
- net income from buying and selling real or personal property which produces income, i.e., capital gains,
- net income from roomers, boarders, or from the rental of property, and
- all other regular sources of income not listed or explicitly excluded below.

Do not include income from the following sources:

- German War Reparations (or reparations from any country)
- Earned income from wages, salary, or stipends received under:
 - Title V
 - JTPA
 - Foster Grandparents
 - Other programs established to foster employment of lower income elderly, such as the Green Thumb Employment Program;
- Unearned income from:
 - One time lump sum payments such as insurance benefits (however, interest or other regular income subsequently received from one-time lump sum payment will be counted as income)
 - Occasional gifts, IT-214, Property Tax Credit/Rebate; and
 - Income from home equity conversion plans, i.e.,

"Reverse Mortgages" (funds received from such plans are debts that must be paid in future).

Do not use the value of goods, services or benefits received in-kind when you calculate monthly income. The value of Food Stamps, HEAP benefits and all other goods, services or benefits received in-kind are not considered income.

- B. Total monthly income:** Add 1-7.
- C. Person will provide no financial information.**

Check the box if person will not provide any financial information. Describe why.

Please continue on to XII. Benefits/Entitlements. Even though the person has refused to provide income information, he/she may be willing to provide other information regarding benefits and entitlements.

Note: Additional information is required from persons who will be receiving EISEP services or CSE-funded EISEP-like services. To gather this information, use the "Cost Determination and Client Agreement" form, or the EISEP "Financial Information & Client Agreement" form, or a locally developed form that includes all of the required information.

XII. BENEFITS AND ENTITLEMENTS

Information obtained in this section will assist the assessor in determining if a person is currently receiving any one of a variety of benefit/entitlement programs. For each of the benefits listed, ascertain and record A, B, C or D under the Benefit Status Code column using the following:

- A. Has the benefit/entitlement;**
- B. Does not have the benefit/entitlement;**
- C. May be eligible and is willing to pursue the benefit/entitlement; or**
- D. Refuses to provide information.**

Also assess whether the person needs information and/or counseling on benefits and entitlement programs.

As you go through the list, it is important to determine if the person was in receipt of a benefit in the past and is no longer in receipt. For example, the person received HEAP benefits in the past, but now the person no longer is receiving HEAP, the assessor can ascertain the reason and may be instrumental in assisting this person to receive the benefit again.

Entitlements and Benefit Categories

Income Related Benefits

Social Security (SS): Self Explanatory

Supplemental Security Income (SSI): A federal program that pays monthly checks to people in need who are 65 years of age or older and to people in need at any age who are blind and disabled. The purpose of the program is to provide sufficient resources so that anyone who is blind or disabled can have a basic monthly income. Eligibility is based on income and assets. A person in receipt of SSI is categorically eligible for Medicaid and should have a Medicaid card.

Railroad Retirement: Persons who worked for a railroad company are entitled to the benefits at retirement (includes Medicare).

Social Security Disability (SSD): A worker who is permanently disabled or has a disability that is expected to last one year or longer may be entitled to the payment of monthly Social Security Disability Insurance benefits if they are covered under Social Security guidelines.

Veteran Status: The person may be eligible for veteran benefits if any of the following conditions exist: the person is a veteran, the person's spouse is/was a veteran, or the person has a deceased child who was a veteran. If any of these criteria are met and the person does not have the benefit, refer the person to the veteran's service agency serving the locality.

Other: Specify.

Entitlements

Medicaid Number: Specify the person's Medicaid number. Medicaid is a government assistance program which pays for a comprehensive range of medical services for persons with low income and assets. There are a number of community based services that a Medicaid eligible individual can receive, such as in-home personal care, Personal Emergency Response Systems (PERS) and transportation, administered by the local Department of Social Services. For persons requiring nursing home care, a separate Medicaid application must be pursued to ensure coverage of the person's nursing home bills. This must be pursued irrespective of the person's current eligibility for "community" Medicaid.

Food Stamps: Coupons that are issued monthly which may be used at any participating store or supermarket to purchase food. Elderly participants may also be qualified to use their food stamps at USDA-approved restaurants. Food stamp eligibility is based upon the person's income and assets.

Public Assistance: A cash benefit that is furnished to individuals or families to provide for essential shelter, food and clothing needs. Public Assistance is divided into two categories, Aid to Families with Dependant Children (AFDC) and Home Relief (HR). Public Assistance (PA) recipients receive semi-monthly cash grants based on financial need, living arrangement and household size. All PA recipients automatically receive Medicaid and most receive Food Stamps.

Other: Specify.

Health Related Benefits

Medicare Number: Specify the person's Medicare number. Medicare is the federal health insurance program for people 65 or older and certain disabled people. Medicare has two parts. Part A, known as Hospital Insurance, covers hospital, skilled nursing facility, home health and hospice care. Part A has deductibles and coinsurance. Part B, known as Medical Insurance, primarily covers doctor's fees, most outpatient hospital services, durable medical equipment and a number of other medical services and supplies that are not covered by Part A. There is a monthly premium for Part B coverage, which is automatically deducted from the person's Social Security check. Part B also has an annual deductible and coinsurance amounts.

Qualified Medicare Beneficiary (QMB): A federal program requiring states to pay the Medicare premiums, deductibles and co-payments for Medicare beneficiaries who qualify based on income and resources.

Specified Low Income Medicare Beneficiary (SLMB): A program that pays a person's Medicare Part B premiums. This program is based on income and assets, however income can be somewhat higher than the income limit for the QMB described above.

Elderly Pharmaceutical Insurance Coverage (EPIC): A program that assists a person with paying for prescription costs. To be eligible, the person must be 65 years of age or older and meet certain financial criteria.

Medigap Insurance/HMO: Medigap insurance is designed to supplement Medicare's benefits by providing specific coverage that helps to fill the gaps in a person's Medicare coverage. There are ten standard medigap plans.

Medicare beneficiaries have a choice in how they may receive their Medicare benefits -- either through traditional, fee-for-service Medicare or through a Medicare managed care plan or HMO. One choice to fill Medicare gaps is enrollment in a Medicare managed care plan or HMO. A Medicare HMO must provide all Medicare-covered services and benefits and most offer additional benefits such as preventive services, prescription coverage, dental care, hearing and or eyeglasses. The person must continue to pay the Medicare Part B premium, some plans charge an additional monthly premium. The HMO usually offers all regular Medicare benefits and may add extra benefits such as

preventive care services and prescriptions.

If the person has the benefit, specify the Medigap insurance or HMO.

Long Term Care Insurance: A policy designed to help cover some of the costs associated with long-term care. Policies covering long term care services currently being sold in New York State are indemnity policies. They pay a specific dollar amount for each day you spend in a nursing facility or for each home health or home care visit. ***New York has established minimum standards for four classifications of insurance policies: long term care insurance, nursing home and home care insurance, nursing home insurance only and home care insurance only. An additional form of LTC insurance is the NYS Partnership for Long Term Care.*** The Partnership program allows those persons who purchase a Partnership policy to qualify for Medicaid without spending down their assets once the benefits under the long term care policy are exhausted. One must contribute their income toward the cost of their care. If person has the benefit, specify the type of LTC insurance.

Other Health Insurance: Person has additional insurance that provides health coverage, such as an employer-sponsored retiree plan, hospital indemnity or specific disease insurance. If the person has the benefit, specify the type of other insurance.

Housing Related Benefits

Senior Citizen Rent Increase Exemption (SCRIE): Tenants aged 62 and over who live in rent controlled or rent stabilized apartments ***in New York City and in several municipalities in Nassau and Westchester Counties*** may qualify for an exemption to rental incomes if their incomes and proportion of their incomes spent on rent meet eligibility guidelines.

Section 8: Federal rental vouchers and rent certificates to provide financial assistance for very low income elderly and families in rental housing, enabling those residents to pay no more than 30% of their incomes on rent.

IT 214: Also known as the Circuit Breaker Program, provides income tax credits or rebates to older homeowners and renters who are paying a disproportionate amount on housing expenses in relation to their household income. A person may qualify for a rebate even if he pays no income tax.

Veteran Tax Exemption: A reduction in property taxes may be available to the veteran or spouse of a veteran. Since there are various options under the Veteran's Tax Exemption, refer the person to the Veteran's Service Agency serving the locality.

Reverse Mortgage: Community banks and financial lenders offer various financial options which allow an older homeowner to use the equity he/she has built up in his/her home as additional sources of regular income. These loans may specify

a specific pay-back date for the principal and interest, but most are repayable upon the death of the homeowner or sale of the home.

Real Property Tax Exemption: New York State allows up to 50% exemption in local real property taxes for older homeowners, with each locality allowed to set its own maximum income eligibility standard.

Home Energy Assistance Program (HEAP): A federally funded program to provide financial assistance to low income persons 60 years of age or older to help pay heating bills.

Weatherization Referral and Packaging Program (WRAP): This program uses special energy case management to provide safe, affordable, energy efficient housing to low income, vulnerable elderly.

Other: Specify.

XIII. CARE PLAN

The Care Plan section aggregates the key information from the rest of this assessment instrument. Through the assessment process, the assessor has identified (1) the person's situation: home environment; health; nutritional status; mental health; functional ability; (2) the person's needs including needs for referrals; and (3) implications for the involvement of formal and informal caregivers to be defined and described in the Care Plan. The Care Plan section of the assessment should be used to bring all the assessment information together and to develop and implement a coordinated plan of care.

While the Care Plan is developed to reflect the person's current situation, the individual developing the Care Plan needs to be sensitive to person's evolving situation. This means that, where indicated, the person developing the Care Plan should note areas to be watchful for because of an unstable or a potentially changing situation (e.g., potential change in caregiver situation, or change in service requirements due to level of need).

The Care Plan should be developed when the assessor completes the assessment. A delay increases the likelihood of changes in the person's condition, resulting in the need to conduct a reassessment. ***If the care plan includes EISEP-funded services or CSE-funded EISEP-like services, it is necessary to complete a Cost Share Determination and Client Agreement or equivalent form.***

Assessors should not be limited to brokering or authorizing existing services. The assessor should strive to challenge the paid formal service system to be more flexible and to accommodate consumer values and preferences, to expand the range of service options available, and to cover new and/or traditional services.

To implement the Care Plan, the assessor should build on the strengths of the

person, be familiar with current community resources, be able to maximize informal supports, be knowledgeable about financing of services, and understand cost arrangements to obtain services.

COMPLETE ALL ITEMS

Date: Enter the date the Care Plan was completed using two digits each for month, day and year. For example, March 12, 2013 would be entered as 03/12/13.

Prepared by: Self-explanatory.

Person's Name: Self-explanatory.

Person's Phone: Self-explanatory.

Address: Specify the address, where services will be provided.

A. Is the person self-directing/able to direct care?

Check yes or no. Determine the person's capacity to make choices about his/her care and ability to understand the impact of those choices. In addition, determine if the person understands the tasks required for his or her care and whether he/she can supervise the staff who will perform the tasks. If the person is not able to direct home care staff, specify who will provide direction.

B. Problems to be Addressed, Goals, Care Plan Objectives, Proposed Time Frame:

Problem(s) to be Addressed: List the problems identified during the assessment that will be addressed in the care plan through the authorization/arrangement of service(s).

Goal(s): The assessor, in consultation with the person and, with the consent of the person, his/her informal caregivers, should prepare goal statements for each problem/need identified through the assessment process that will be addressed. Specify goals only for problems for which some type of service or care is indicated. Do not list activities that the person can do alone or for which the person has compensated and requires no additional intervention. (**See example, below.**)

Goal statements should be concise and specific. Whenever possible, they should be stated in functional terms that are observable or measurable so that the person, informal caregiver(s) and assessor can tell whether the person has reached goals and related objectives.

For each goal, it will become possible to identify desired outcomes that the

person, informal caregiver, and assessor expect will result from the service intervention. At the point when a service or the care plan is being terminated, it will be possible to compare the stated goal(s) to client outcomes to determine if the goal(s) have been reached.

Care Plan Objectives: The objective(s) are steps toward reaching a stated goal. Objectives should be concise and specific. (*See example, below.*)

Proposed Time Frame: For all goal statements, a reasonable time frame/limit for achievement of the goal should be specified. This applies to persons where the goal relates to maintenance of function, intervention to help with person's declining ability, as well as goals for improvement. (*See example, below.*)

An example of client problems, goals, objectives and proposed time frames follows. In this example, the client is expected to improve with the service intervention in terms of ability to manage at home, and maintain this status over time:

Example: Problems: Person has difficulty preparing food, and with bathing and dressing due to arthritis limiting use of hands.

Goals: Nutrition - Stable nutritional status.
Bathing - Self-manage bathing with caregiver assistance.
Dressing - Independent dressing with fastening assistance from caregiver.

<p><u>1. Objectives:</u></p> <p>(1) Train person in content of modified diet so can select appropriate groceries and plan menus.</p> <p>(2) Supply utensils so person can prepare nutritious meals at home.</p> <p>(3) Supplement with home delivered meals.</p>	<p>Proposed time frame:</p> <p>(1) 12 weeks</p> <p>(2) 4 weeks</p> <p>(3) on-going</p>
<p><u>2. Objective:</u> Bathing: Have home care worker sponge bathe client and teach client and caregiver how to do properly.</p>	<p>Proposed time frame:</p> <p>3 weeks</p>
<p><u>3. Objectives:</u> Dressing:</p> <p>(1) Develop skills of client and informal</p>	<p>Proposed time frame:</p> <p>(1) 12 weeks</p>

caregiver to help the client with dressing.	
(2) Discuss with person availability of clothing that she can manage.	(2) 2 Weeks

PLEASE NOTE THE FOLLOWING:

- Problems to be addressed can include inability to perform IADL or ADL tasks, psycho-behavioral condition of the person, or the person's treatment of caregivers; anything, that is, that affects the development and implementation of a plan of care for the person.
- State problems in functional terms, e.g., "cannot do . . .," "has difficulty with
- Provide the reason for each problem. These statements are important because they can imply root cause or different service requirements. For example, "cannot cook" might be due to blindness, or because the person lacks a stove or does not know how to cook.
- Group together all problems that are similar or have the same root cause or reason, and might be met by the same service. ***For example, the person cannot do household chores and shopping because he or she is blind; person cannot do bathing, dressing, toileting due to limited mobility caused by a broken hip. Be specific and brief.***

Goal statements are different from the list of services to be provided.

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

Unless there are very unusual circumstances, the person and, with the person's consent, his/her informal caregiver(s) should always be present and involved in the development of the Care Plan. To the extent possible within the context of payer requirements, the Care Plan should reflect the choices, values and preferences of the person and his/her informal caregiver(s). This would include timing and frequency of services delivered, how services are to be delivered, how instructions to the care provider will be handled, and preferences concerning cultural beliefs and language.

D. Types of Services to be provided: The Care Plan should list the specific types of help the person needs to reach specified goals. Enter any service to be provided, whether it is a paid formal service or services provided by informal caregivers. Enter services by service name (i.e., case management, housekeeping/chore, homemaking/personal care, home delivered meals, social adult day care, etc.). When both a paid formal

provider and an informal caregiver will provide the same type of service (e.g., personal care), list that service twice. You should specify tasks the informal and/or formal provider(s) are to do, for all services the person will be receiving, regardless of payer. The types of formal providers vary somewhat according to the county in which the person lives, but can include the Medicaid Personal Care Program, Public Health Nursing, Social Adult Day Care Program, Home Delivered Meals, Counseling Services, Friendly Visitor Program, Telephone Reassurance, and/or other formal services available in the county.

How Much: How many days per week and how many hours per day/week.

When: The specific days of the week when services are to be provided i.e. Monday AM, Wednesday PM at 1:00, etc.

Frequency: Enter the appropriate frequency for the delivery of the service (i.e. daily, every week, every other week, once a month, etc.). Specify "one time only" if the service is provided once (for example, an EISEP ancillary service, or weatherization).

Start Date for the service. Enter as six digits, e.g., 05-09-97. For ancillary services, enter purchase date or project starting date, as appropriate. This date may be left blank if the person is placed on a waiting list for a service.

Projected End Date (if known). Enter as six digits, e.g., 08-09-97. This date may be left blank if no projection of service duration can be made at the time of completion of the Care Plan.

Formal/Informal: Specify if the care will be provided by a formal service provider or through an informal caregiver such as family, friends, neighbors, and/or community/neighborhood group.

Name of the Provider who will be providing services.

- E. Problems to be Referred** to other programs: List other problems indicated in the assessment that are to be addressed by other agencies or programs. Services to which the person is to be referred must be considered in the development and implementation of the Care Plan.
Please see the Appendix for INDICATORS FOR REFERRALS.

Specify all services for which the person will be referred to address these assessed needs. Referrals may also be made to supplement services listed in D. above.

Referred to: Specify the name of the provider (i.e. Public Health Agency, Adult Protective Services, etc.) who will be providing services.

- F. Information/Special Instructions That Have Direct Bearing on**

Implementation of This Care Plan: Include any additional information/instructions that have direct bearing on implementation of the Care Plan. For example -- person has large dog that is not friendly to others.

- G. Has the person been placed on a waiting list for any service need?**
Check yes or no. If yes, indicate the name of the service, provider name, and the date the person was placed on the waiting list. As much as possible, the Care Plan should be carried out according to the timetable set forth in the Care Plan. If too long a delay occurs, a reassessment of the person may be necessary.
- H. Plan has been discussed and accepted by client and/or informal supports:** Check yes or no to indicate whether the person and/or informal supports accept the Care Plan. We expect that in most instances the person would be involved in these discussions and decisions, and the informal supports would be involved as appropriate and necessary. If not, explain why not.

Please Note The Following: The person and his or her informal caregivers have the right to comment on the Care Plan. This includes commenting on the adequacy of the Care Plan; refusing services on any part of the Care Plan without fear of loss of other services, except if the person's safety becomes at-risk or if parts of the care plan are essential to meet program requirements. For example, case management is required to receive other EISEP-funded services.

If the Care Plan includes EISEP or CSE EISEP-like services, the assessor must complete the EISEP Cost Share Determination and Client Agreement or equivalent form. The person and his or her informal caregiver(s), as appropriate must be informed about cost-sharing responsibilities, if any.

The assessor must inform the person's informal caregiver(s) and service providers that will be involved in the person's care of relevant information from the assessment and Care Plan. At a minimum, this includes goals of care delivery, information about types of services to meet the person's needs and time frame. For some services, greater detail will be required.

Care providers, both formal and informal, should know which care providers will be participating in the person's care and the extent and timing of their help. The assessor should discuss and delineate the roles and responsibilities of the consumer in ensuring the success of the Care Plan.

The assessor should carefully discuss all reasonable care and residential housing options with the person and her/his informal caregiver(s). The assessor should discuss advantages and disadvantages of each including the risks associated with care and the costs and funding sources available. The assessor should leave the final decision to the person and,

if appropriate, her/his informal caregiver(s).

- I. **Plan Approved By:** If someone other than the assessor approves the Care Plan, enter name, signature and title of the person who approved the Care Plan. Enter the date the Care Plan was approved using two digits each for month, day and year. For example, March 12, 2013 would be entered as 03/12/13.

APPENDIX

A. INDICATORS FOR REFERRAL

PLEASE NOTE THE FOLLOWING: Indicators for Health Assessment and/or Mental Health Assessment Referral are gathered from Section III, Health Status and Section V, Psycho-Social Status.

BACKGROUND:

A person in need of non-medical support services may have an undiagnosed and/or untreated condition that requires attention. Or, a previously known condition may have worsened so that assessment and treatment may become necessary. The indicators for health or mental health referral discussed here identify certain observations that may suggest the need for a health or mental health professional's examination.

The indicators should be considered during any contact with the person: assessment, reassessment, home visits to assure quality of care, or in any other part of the ongoing case management process. Further, they can be used to inform any other individuals coming in contact with the person, including informal supports or formal caregivers.

PROCESS FOR IDENTIFYING INDICATORS:

1. **Observation:** Certain conditions may be identified by the case manager through observation. Use the following indicators list as a guide for things to look for. Looking closely at the person can disclose abnormalities; in general, what would look abnormal on the case manager is also abnormal when seen on an older person (e.g., swelling of an extremity or puffiness around the eyes).
2. **Ask about conditions and changes in conditions:** The case manager can ask in a general way for the person to identify any conditions or changes in conditions that the person thinks might be important for the case manager to know about. If observation shows a condition not mentioned by the person, further probing is appropriate. It is also appropriate to seek further information from other knowledgeable individuals.
3. **Discover if a physician or other health professional has diagnosed a condition.** Whether observed by the case manager or identified by the person in response to questions, ask if the condition has been diagnosed by a

physician or other health professional. If the person states a condition in terms of a diagnosis or disease (i.e., "I have high blood pressure" or "I have congestive heart failure"), find out if the statement reflects a physician diagnosis.

If the person states that the condition has been diagnosed, the assessor may, if necessary to verify the diagnosis, seek confirmation from other knowledgeable persons: family members, informal supports, etc. Confirmation can help identify circumstances in which the diagnosis has not been made by a health professional, or provide more detail on duration and incidence than remembered by the person.

On a first assessment, the only source of information about changes in condition will come from the person, informal supports, family, etc.

4. **Ask about treatments ordered:** If the condition has been diagnosed by a physician or other health professional, ask if treatment has been ordered and determine if the treatment is being followed.

REFERRAL IS NEEDED IF:

- The condition has not been diagnosed;
- The condition has changed;
- Treatment has not been ordered; or
- The treatment is not being followed.

REFERRAL ORDER:

1. Usually, referral should be to the person's primary medical provider: personal physician or usual medical provider (clinic, HMO, etc.) if any.
2. Follow the instructions of the primary provider if referral to another health professional is indicated (e.g., a physical therapist if ordered by a physician).
3. When the person has no regular medical provider, referral will be to a local public health nursing service.

Exception: In the case of a psycho-behavioral indicator, referral may be directly to a mental health professional.

Follow-up: After referral, determine the results of the professional assessment and the effect on the care plan.

INDICATORS:

General: With some persons, there may be a tendency to minimize the importance of a condition, especially if long lasting. The important criteria are whether diagnosis and treatment have occurred, and if change has occurred

from chronic to acute distress. Acute distress usually is suggested as the condition becomes the total object of the person's attention. Another useful guide is the swiftness of onset of a condition or change. A condition that has developed over the course of a few hours to a day is more likely to be serious.

The following lists contain indicators of need for referral if the condition exists and is not under treatment, or if change has occurred. The first three are noted as indicators of need for emergency treatment to prevent serious illness, injury or death. Other items may indicate need for emergency treatment, especially if change has been abrupt or distress is acute.

THE FOLLOWING ARE INDICATORS OF PHYSICAL CONDITIONS NEEDING REFERRAL:

- Person appears to be sleeping comfortably but cannot be wakened: emergency;
- Frequent falls: if a fall is associated with severe pain or bruising, or obvious broken limb: emergency;
- Chest pain, chest pressure, pain radiating from chest down arms, or severe indigestion or vomiting: emergency;
- Swelling of a body part; report which part(s) is swollen;
- Poor skin color, especially on face or in limbs;
- Difficulty breathing, or easily winded whether with exertion or just in conversation;
- Strong odors of urine or feces;
- Frequent inebriation;
- Open sores, whether they appear infected or not, and especially if not healing promptly;
- Very dry, flaking skin;
- Frequent going to the bathroom, whether voiding urine or feces, not related to an acute condition;
- Frequent or unusual nausea, vomiting or dizziness;
- Frequent headaches;
- Several bruises, particularly if on extremities;
- Bleeding, from wound on body or into urine or feces.

THE FOLLOWING ARE INDICATORS OF PSYCHO-BEHAVIORAL CONDITIONS NEEDING MENTAL HEALTH REFERRAL:

- Memory loss;
- Hallucinations.

THE FOLLOWING TWO LISTS ARE INDICATORS OF NEED FOR REFERRAL WHEN THERE ARE SIGNIFICANT CHANGES IN PHYSICAL OR PSYCHO-BEHAVIORAL CONDITION:

CHANGE IN PHYSICAL CONDITIONS NEEDING REFERRAL:

- Large **INVOLUNTARY** change in weight (more than 10 pounds in six months);
- Change in capacity to perform IADLs or ADLs if such change is not directly related to an obvious cause. For example, change in capacity due to an acute respiratory infection or after surgery would not count here;
- Loss of appetite, or other major change in appetite or dietary intake;
- Change in sleep pattern, whether to much more or much less than previous normal;
- Increase in thirst;
- Change in ability to communicate verbally (oral or writing);
- Change in strength or stamina;
- Change in awareness of or interest in surroundings;
- Change in sensory ability.

CHANGE IN PSYCHO-BEHAVIORAL CONDITIONS NEEDING REFERRAL:

- Change in social interactions, reducing previously maintained contacts;
- Change in personal behavior, as in mode of dressing, aggressiveness, or ability to make judgments not related to change in physical capacity.

OTHER CONSIDERATIONS:

Follow up: While the COMPASS does not record this, the assessor or other case manager will follow up on the referral(s). The assessor or case manager will have to decide whether the assessment for non-medical services must wait for a report from the referral before a care plan can be made and put into operation. In such cases, inform the person of the need for a report of the referral.

Refusal to accept referral: A person retains the right to refuse medical treatment, including assessment. If you decide that such choice may not reflect informed decision-making or subjects the person to imminent risk of serious harm, you should employ the usual procedures to refer the case to Protective Services for Adults of the local Department of Social Services.

If referral is refused, you may have to conclude that the information to be gained from the referral is necessary to decide that the person can be maintained safely at home. If you believe that the person can not be served safely at home you must make an appropriate referral, e.g., police department, fire department, Protective Services for Adults.

B. Assistance With Questions Regarding Sexual Orientation and Transgender Status - Provided by Services & Advocacy for Gay, Lesbian Bisexual and Transgender Elders, (SAGE)

Transgender - If the client is confused or put off by this, you can say something like this:

I understand that this issue might be very clear for you, but some people have an experience of their gender that is unique to them, and that other people might not be able to see. I want to give all my clients the respect and freedom of defining themselves.

If a person seems confused by the wording of the question but is struggling because they may indeed identify as transgender but not with that term, you could clarify by saying: If a client needs help with this idea: For some people, their body is a male body but inside they feel like a woman. Or they have a female body, but inside, they feel like a man. Have you ever had feelings like that?

If the client says they are transgender, say:
I'm glad you told me that.
What would you like me to call you?
What pronoun would you like me to use?

If they client identifies their gender or sexuality by using a word you're not familiar with; say OK, that's a new word for me. But I want to support you and I want to understand you, so, what does that mean to you? Is that a word that would be appropriate for me to use too, or is that a word that only someone who sees themselves as [genderqueer] would use?

Sexual Orientation – These questions, along with all the other questions you are being asked, are designed for us to get to know you better so that we can offer you the best care possible. It is important for us to understand your needs and the services we may be able to provide for you.

Emphasize that a client's sexual orientation or gender identity will not be discussed with his/her family or friends without the client's specific permission.

If a client does not understand what some of the terms may mean, consider the following definitions:

Heterosexual or straight: Used to describe people whose primary physical, romantic, and/or emotional attraction is to people of the opposite sex.

Lesbian: A woman whose primary physical, romantic, and or/emotional attraction is to other women. Some lesbians may prefer to identify as gay (adj.) or as gay women.

Gay: A word used to describe anyone, mainly men, who have primary physical, romantic, and/or emotional attraction to someone of the same sex, e.g., gay man, gay people. Many gay people prefer this term over "homosexual" which retains negative connotations.

Bisexual: An individual who is physically, romantically, and/or emotionally attracted to both men and women. "Bisexual" does not suggest having equal sexual experience with both men and women.

Not sure: If a client says “not sure,” attempt to clarify if the person is unsure of their own sexual orientation (perhaps because they are questioning it themselves) or if they are unclear of what the question means. If the latter, attempt to clarify the question and answers. If the former, consider making a note in the client’s chart so as to consider this when developing the care plan.

Did not answer: If a client does not answer because they feel the question is intrusive, attempt to remind the person of the level of confidentiality they can expect, as well as why all of the questions are being asked. If the person still does not want to answer, do not force them to give you this information and check this box instead.

Other: There may be other categories that a person considers, such as “asexual.” If the category the person suggests is not one of the options, “other” is the appropriate box to check.

SERVICE/CARE PLAN TERMINATION

This section is completed only when service(s) that the client is currently receiving is/are being discontinued or the Care Plan is being terminated.

Its purpose is to document when and why Service(s) or the Care Plan is/are being discontinued and to identify the outcome(s) from the service(s) provided.

- A. What is being terminated?** Check service when service(s) will no longer be provided. ***Note that this does not apply to a change in the amount or frequency of a particular service.*** Specify which service(s) will be discontinued.

Check Care Plan if all services the client currently is receiving are being discontinued.

- B. Termination Date:** Enter the date that the service(s) or Care Plan is/are being terminated using two digits for each month, day and year. For example, June 19, 1998 would be entered as 06/10/98.

- C. Reason for Termination:** Check the reason which best describes why the service(s) or care plan is/are being discontinued.

- 1. Goal Met:** The Goal(s) listed in the Care Plan has/have been met and therefore service(s) is/are no longer needed. Specify which goal(s) has/have been met as indicated in the Care Plan.
- 2. Independence:** The client has regained enough capacity so that he/she no longer requires the service(s).
- 3. Client Request:** The client asks that the service(s) be discontinued.
- 4. Client Relocated:** Self explanatory.

5. **Hospitalization:** Self explanatory.
6. **Nursing Home or Assisted Living Facility Placement:** Self explanatory
7. **Death:** Self explanatory
8. **Other:** If service(s) is/are being discontinued for another reason, check and specify the reason. For example, when a service is being replaced by another, such as Home Delivered Meals being replaced by a home care worker who will prepare a meal.

D. Service or Care Plan Related Client Outcome Statements:

Client outcome statements should be concise and specific showing whether the person has reached goals and related objectives for each problem addressed by the particular service or care plan as appropriate, in the targeted time frame(s). For example, if problem was "difficulty with preparing food" (due to arthritis limiting use of hands), and a desired goal was "Stable Nutrition Status," state whether the service(s) helped the person reach this goal, and if not, explain why not, if appropriate.

- E. Plan Terminated By:** *Complete this only when the care plan is being terminated.* The person terminating the care plan must sign on the appropriate line. Enter the title of the person and his/her phone number. Enter the date using two digits for each month, day and year. For example, July 20, 2013 would be entered as 07/20/13.

MINIMUM DATA SET

(April 2013)

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

Housekeeper/Chore, Homemaker/Personal Care, Case Management, Home Health Aide Services, Home Delivered Meals 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 not 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, With Spouse & Others, With Relatives, 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.

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

ATTACHMENT A

SUMMARY TABLE

April 1, 2013

TABLE #	FILE NAME	DESCRIPTION	FORMAT	File Length	TABLE REQUIRED FOR:			
					CLUSTER 1	CLUSTER 2	CLUSTER 3	CARE GIVERS
1	CLIENTS.TXT	Basic client identifying data, Nutrition	1 record per client	202	YES	YES	YES *	YES
2	SERVICES.TXT	Monthly units of service delivered	1 record per month/quarter per service per fund per client	33	YES	YES	YES *	YES
3	ADLIADL.TXT	Client ADL/IADL needs	1 record per ADL/IADL per client	74	YES			
4	CHARACTERISTICS.TXT	Client Characteristics	1 record per characteristic per client	15	YES			
5	HEALTHEVENTS.TXT	Health Events	1 record per event per client	24	YES			
6	CAREPLANS.TXT	Care Plan Services	1 record per service per client	31	YES			
7	CAREGIVERS.TXT	Caregiver types & relationships	1 record per service per relationship	14	YES			YES
8	ELDERABUSE.TXT	Elder Abuse type & referrals	1 record per abuse	22	YES			
CLUSTER 1:		Personal Care Level 2 (H/PC), Personal Care Level 1 (H/Chore) , Case Management, Consumer Directed In-Home, Home Health Aide, Adult Day Care Services and Home Delivered Meals						
CLUSTER 2:		Congregate Meals, Assisted Transport, Nutrition Counseling						
CLUSTER 3:		Transportation, Legal Services, Nutrition Education, Information & Assistance, Outreach, In-Home Contact & Support, Sr. Center Recreation/Education, Health Promotion, PERS, Caregiver Services, and Other						
CAREGIVERS:		Access Assistance, Counseling/Support Groups/Training, Information Services, Supplemental Services, Respite Care						

* Information collected by these files allows the AAA to report units of service provided to recipients for other services.

CLIENT DATA SPECIFICATIONS - April 2013

Table #: 1
 File Content CLIENT DEMOGRAPHICS AND OTHER DATA
 Format: One record per client

File Name: CLIENTS.TXT
 STATUS: REQUIRED FOR CLUSTER 1, CLUSTER 2
 & CAREGIVER CLIENTS

SERVICE CLUSTER			GENERAL CLIENT INFORMATION		Start	End	
1	2	3	CG	Field Name	Length	Pos.	Codes or See Att. B
R	R	R	R	County Code	2	1	2 See Att. B Sec. A
R	R	R	R	Record Number/KEY*	10	3	12 Locally Assigned
M				Last 4 Digits Social Security Number	4	13	16
R	R	M	R	Zip Code	5	17	21
R	R	M	R	Rural/Urban Designation	1	22	22 R or U
R	R	M	R	Date of Birth (mm/dd/yyyy)	10	23	32
R	R	M	R	Race Code	1	33	33 0=Unknown\Missing 1=Amer Ind/Alaskan Native 2=Asian 3=Black or African American 4=White (Alone) Hispanic 5=White not Hispanic 6=Native Hawaiian/Other Pacific Islander 7=Other Race 8=2 or More Races
R	R	M	R	Ethnic Code	1	34	34 0=Unknown\Missing 1= Hispanic or Latino 2=Not Hispanic or Latino
R	R	M	R	Limited English Proficiency	1	35	35 Y or T or 1; N or F or 2; blank = Unknown
R	R	M	R	Sex	1	36	36 M or 1; F or 2
R				Creed Code	1	37	37 1=Christianity 2=Islam 3=Hinduism 4=Buddhism 5=Judaism 6=Did Not Answer 7=Other
R				National Origin	3	38	40 See Att. B Sec. H
R				Sexual Orientation	1	41	41 1=Heterosexual or Straight

Table #: 1
 File Content CLIENT DEMOGRAPHICS AND OTHER DATA
 Format: One record per client

File Name: CLIENTS.TXT
 STATUS: REQUIRED FOR CLUSTER 1, CLUSTER 2
 & CAREGIVER CLIENTS

SERVICE CLUSTER			GENERAL CLIENT INFORMATION	Start	End	
1	2	3	CG Field Name	Length	Pos.	Pos. Codes or See Att. B
R			Transgender - Gender Identity or Expression	1	42	42 2=Homosexual or Gay 3=Lesbian 4=Bisexual 5=Not Sure 6=Did Not Answer 7=Other 1=Male to Female 2=Female to Male 3=Transgender, did not identify as male or female 4=No 5=Did not answer

Table #: 1
 File Content CLIENT DEMOGRAPHICS AND OTHER DATA
 Format: One record per client

File Name: CLIENTS.TXT
 STATUS: REQUIRED FOR CLUSTER 1, CLUSTER 2
 & CAREGIVER CLIENTS

SERVICE CLUSTER			GENERAL CLIENT INFORMATION		Start	End		
1	2	3	CG	Field Name	Length	Pos.	Pos.	Codes or See Att. B
R	R	M		Veteran Status	1	43	43	Y or T or 1; N or F or 2; blank = Unknown
R	R	M		Living Status	1	44	44	1=Alone 2=With Spouse Only 3=With relatives 4=With non-relatives 5=With Spouse and others 6=Others
R	R	M		Number in Household	2	45	46	
R	R	M		Marital Status	1	47	47	1=Married 2=Widowed 3=Domestic Partner or Significant Other 4=Divorced 5=Single/Never Married 6=Separated
R	R	M		Frail/Disabled Indicator	1	48	48	Y or T or 1; N or F or 2; blank = Unknown
R	R	M		Activation/Registration Date(mm/dd/yyyy)**	10	49	58	
R	R	R	R	Status Code	1	59	59	1=Active; 2=Inactive or Terminated
R	R	R	R	Sub-status Code	2	60	61	See Att. B Sec. B
R	R	R	R	Date of Current Status (mm/dd/yyyy)***	10	62	71	
R				Assessment Date (mm/dd/yyyy)	10	72	81	
M				Type of Housing	3	82	84	001 or 108 = Single Family 102 or 107 = Multi-Family
M				Housing Ownership	1	85	85	1=Rent; 2=Own; 3=Other
M				Disabled Veteran Status	1	86	86	Y or T or 1; N or F or 2; blank = Unknown
<u>Financial Information:</u>								
R	R	M		Total Monthly Income OR	5	87	91	Dollars only See Note B
R	R	M		Total Annual Income OR	5	92	96	Dollars only See Note B
R	R	M		Poverty Status				
				Below 100% Poverty Level	1	97	97	Y or T or 1; N or F or 2; blank = Unknown See Note B
				Below 150% Poverty Level	1	98	98	Y or T or 1; N or F or 2; blank = Unknown See Note B

Table #: 1
 File Content CLIENT DEMOGRAPHICS AND OTHER DATA
 Format: One record per client

File Name: CLIENTS.TXT
 STATUS: REQUIRED FOR CLUSTER 1, CLUSTER 2
 & CAREGIVER CLIENTS

SERVICE CLUSTER	GENERAL CLIENT INFORMATION	Start	End		
1	2	3	CG	Field Name	Length Pos. Pos. Codes or See Att. B
				<u>Cost Share Status:</u>	
R				Overall cost share % (000 thru 100)	3 99 101 See Note C
M				Total Monthly Housing Expenses	5 102 106 Dollars only See Note C
				<u>Nutritional Risk Status:</u>	
R	R			Client has illness/condition that changes kind/amount of food eaten	1 107 107 Y or T or 1; N or F or 2; blank = Unknown
R	R			Eats fewer than 2 meals/day	1 108 108 Y or T or 1; N or F or 2; blank = Unknown
R	R			Eats few fruits or vegetables, or milk products.	1 109 109 Y or T or 1; N or F or 2; blank = Unknown
				BLANK	1 110 110
				BLANK	1 111 111
R	R			Has 3+ drinks of beer/wine/liquor almost every day	1 112 112 Y or T or 1; N or F or 2; blank = Unknown
R	R			Has tooth/mouth problems making it hard to eat	1 113 113 Y or T or 1; N or F or 2; blank = Unknown
				Does not always have enough money to buy food needed	1 114 114 Y or T or 1; N or F or 2; blank = Unknown
R	R			Eats alone most of the time	1 115 115 Y or T or 1; N or F or 2; blank = Unknown
R	R			Takes 3+ prescribed/over-the-counter drugs/day	1 116 116 Y or T or 1; N or F or 2; blank = Unknown
R	R			Lost or gained 10 pounds in last 6 months	1 117 117 Y or T or 1; N or F or 2; blank = Unknown
				Not always able to physically shop, cook and/or feed self	1 118 118 Y or T or 1; N or F or 2; blank = Unknown
R				Body Mass Index (format is 99.9) OR	4 119 122 See Note E
R				Height (inches) AND	3 123 125 See Note E
R				Weight (lbs)	3 126 128 See Note E

Alcohol Screening Test:					
R				Have you ever felt you should cut down on your drinking?	1 129 129 Y or T or 1; N or F or 2; blank = Unknown
R				Have people annoyed you by criticizing your drinking?	1 130 130 Y or T or 1; N or F or 2; blank = Unknown
R				Have you ever felt bad or guilty about your drinking?	1 131 131 Y or T or 1; N or F or 2; blank = Unknown
R				Have you ever had a drink first thing in the morning	1 132 132 Y or T or 1; N or F or 2; blank = Unknown

Table #: 1
 File Content CLIENT DEMOGRAPHICS AND OTHER DATA
 Format: One record per client

File Name: CLIENTS.TXT
 STATUS: REQUIRED FOR CLUSTER 1, CLUSTER 2
 & CAREGIVER CLIENTS

SERVICE CLUSTER	GENERAL CLIENT INFORMATION	Start	End	
1 2 3	CG Field Name	Length	Pos.	Pos. Codes or See Att. B
	<u>Informal Supports - Up to two Supports</u>			
	For Primary Informal Support, if one exists:			
R	a. Relationship of Informal Support	2	133	134 See Att. B Sec. C
M	b. Factors that might limit caregiver involvement:			
M	Job	1	135	135 Y or T or 1; N or F or 2; blank = Unknown
M	Finances	1	136	136 Y or T or 1; N or F or 2; blank = Unknown
M	Family Responsibilities	1	137	137 Y or T or 1; N or F or 2; blank = Unknown
M	Physical Burden	1	138	138 Y or T or 1; N or F or 2; blank = Unknown
M	Emotional Burden	1	139	139 Y or T or 1; N or F or 2; blank = Unknown
M	Health Problems	1	140	140 Y or T or 1; N or F or 2; blank = Unknown
M	Reliability	1	141	141 Y or T or 1; N or F or 2; blank = Unknown
M	Other	1	142	142 Y or T or 1; N or F or 2; blank = Unknown
M	c. Is Caregiver relief needed?	1	143	143 Y or T or 1; N or F or 2; blank = Unknown
M	If yes, when?	2	144	145 11-Morning 12-Afternoon 13-Evening 14-Overnight 15-Weekend 16-Other
R	d. Would this person be considered the caregiver	1	146	146 Y or T or 1; N or F or 2; blank = Unknown
	For Second Informal Support, if one exists:			
M	a. Relationship of Informal Support	2	147	148 See Att. B Sec. C
M	b. Factors that might limit caregiver involvement:			
M	Job	1	149	149 Y or T or 1; N or F or 2; blank = Unknown
M	Finances	1	150	150 Y or T or 1; N or F or 2; blank = Unknown
M	Family Responsibilities	1	151	151 Y or T or 1; N or F or 2; blank = Unknown
M	Physical Burden	1	152	152 Y or T or 1; N or F or 2; blank = Unknown
M	Emotional Burden	1	153	153 Y or T or 1; N or F or 2; blank = Unknown
M	Health Problems	1	154	154 Y or T or 1; N or F or 2; blank = Unknown
M	Reliability	1	155	155 Y or T or 1; N or F or 2; blank = Unknown
M	Other	1	156	156 Y or T or 1; N or F or 2; blank = Unknown
M	c. Is Caregiver relief needed?	1	157	157 Y or T or 1; N or F or 2; blank = Unknown
M	If yes, when?	2	158	159 11-Morning 12-Afternoon 13-Evening 14-Overnight 15-Weekend 16-Other
M	d. Would this person be considered the caregiver	1	160	160 Y or T or 1; N or F or 2; blank = Unknown
M	Overall Evaluation of Informal Support System	1	161	161 1-Adequate, Can Expand if needed 2-Adequate, Could not expand

See Note F

Table #: 1
 File Content CLIENT DEMOGRAPHICS AND OTHER DATA
 Format: One record per client

File Name: CLIENTS.TXT
 STATUS: REQUIRED FOR CLUSTER 1, CLUSTER 2
 & CAREGIVER CLIENTS

SERVICE CLUSTER	GENERAL CLIENT INFORMATION	Start	End	
1 2 3	CG Field Name	Length	Pos.	Pos. Codes or See Att. B
				3-Inadequate/Limited 4-Temporarily Unavailable 5-Other
	<u>Client Receive/Have Following Benefits/Entitlements?</u>			
M	EPIC	1	162	162 Y or T or 1; N or F or 2; blank = Unknown
M	Food Stamps (SNAP)	1	163	163 Y or T or 1; N or F or 2; blank = Unknown
M	Health Insurance	1	164	164 Y or T or 1; N or F or 2; blank = Unknown
M	HEAP	1	165	165 Y or T or 1; N or F or 2; blank = Unknown
M	IT-214	1	166	166 Y or T or 1; N or F or 2; blank = Unknown
M	Lifeline/PERS	1	167	167 Y or T or 1; N or F or 2; blank = Unknown
M	Long Term Care Insurance	1	168	168 Y or T or 1; N or F or 2; blank = Unknown
M	Medicaid	1	169	169 Y or T or 1; N or F or 2; blank = Unknown
M	Medicare	1	170	170 Y or T or 1; N or F or 2; blank = Unknown
M	Medicare Part D	1	171	171 Y or T or 1; N or F or 2; blank = Unknown
M	Medigap Insurance/HMO	1	172	172 Y or T or 1; N or F or 2; blank = Unknown
M	Private Health Insurance	1	173	173 Y or T or 1; N or F or 2; blank = Unknown
M	Public Assistance	1	174	174 Y or T or 1; N or F or 2; blank = Unknown
M	QMB	1	175	175 Y or T or 1; N or F or 2; blank = Unknown
M	Railroad Retirement	1	176	176 Y or T or 1; N or F or 2; blank = Unknown
M	Real Property Tax Exemption (STAR)	1	177	177 Y or T or 1; N or F or 2; blank = Unknown
M	Reverse Mortgage	1	178	178 Y or T or 1; N or F or 2; blank = Unknown
M	Section 8 Housing	1	179	179 Y or T or 1; N or F or 2; blank = Unknown
M	SLIMB	1	180	180 Y or T or 1; N or F or 2; blank = Unknown
M	Social Security	1	181	181 Y or T or 1; N or F or 2; blank = Unknown
M	SSD	1	182	182 Y or T or 1; N or F or 2; blank = Unknown
M	SSI	1	183	183 Y or T or 1; N or F or 2; blank = Unknown
M	VA Benefits	1	184	184 Y or T or 1; N or F or 2; blank = Unknown
M	Veteran Tax Exemption	1	185	185 Y or T or 1; N or F or 2; blank = Unknown
M	WRAP	1	186	186 Y or T or 1; N or F or 2; blank = Unknown

Table #: 1
 File Content CLIENT DEMOGRAPHICS AND OTHER DATA
 Format: One record per client

File Name: CLIENTS.TXT
 STATUS: REQUIRED FOR CLUSTER 1, CLUSTER 2
 & CAREGIVER CLIENTS

SERVICE CLUSTER			GENERAL CLIENT INFORMATION		Start	End	
1	2	3	CG	Field Name	Length	Pos.	Pos. Codes or See Att. B
<u>Does Client Participate in the following Program(s):</u>							
R	R			Community Living Program	1	187	187 Y or T or 1; N or F or 2; blank = Unknown
R	R			Chronic Disease Self Management Program	1	188	188 Y or T or 1; N or F or 2; blank = Unknown
R	R			Integrated Systems Grant Part A	1	189	189 Y or T or 1; N or F or 2; blank = Unknown
R	R			Other Programs as Defined by NYSOFA	1	190	190 Y or T or 1; N or F or 2; blank = Unknown
<u>Client Receiving Eligible Meals Who Are Otherwise Non-Eligible</u>							
R	R			Under 60 Spouses of eligible seniors	1	191	191 Y or T or 1; N or F or 2; blank = Unknown
R	R			Disabled Persons living in senior housing	1	192	192 Y or T or 1; N or F or 2; blank = Unknown
R	R			USDA eligible volunteers under 60	1	193	193 Y or T or 1; N or F or 2; blank = Unknown
R	R			Disabled Persons living at home w\eligible person	1	194	194 Y or T or 1; N or F or 2; blank = Unknown
<u>Unique Client Identifier</u>							
R	R	R	R	First letter of First Name	1	195	195
R	R	R	R	First three letters of Last Name	3	196	198
R	R	R	R	Last 4 digits of phone number	4	199	202

See Note G

Total 202

* Client's Record Number/KEY must remain the same each submission.

** Activation/Registration Date - This is the date that the AAA begins interacting with the client, either through conducting an assessment or registering him/her for a service or providing a service. This date corresponds to when the client becomes "Active." It is not for a specific service.

*** Date of Current Status - This is the date of the client's most current status. If the client is active, it would same date as the be the activation/registration date. If the client is terminated, it would be the date terminated. If s/he were reactivated, would be the date the client was reactivated.

Table #: 1
 File Content CLIENT DEMOGRAPHICS AND OTHER DATA
 Format: One record per client

File Name: CLIENTS.TXT
 STATUS: REQUIRED FOR CLUSTER 1, CLUSTER 2
 & CAREGIVER CLIENTS

SERVICE CLUSTER			GENERAL CLIENT INFORMATION	Start	End		
1	2	3	CG Field Name	Length	Pos.	Pos.	Codes or See Att. B

NOTES

- A Provide both the client's Zip Code and Urban/Rural Indicator
- B Provide EITHER Monthly Income OR Annual Income OR Poverty Status for both 100% and 150% of the poverty level.
 Note, when including monthly\annual income & poverty levels, the correct poverty levels are checked.
- C Required only for clients receiving EISEP or CSE services for which there is cost sharing. Leave blank otherwise.
- D Required for clients receiving Case Management, Home Delivered Meals, Nutrition Counseling and Congregate Meals. See Data Requirements item #8 in the Reporting Guide Consolidated Area Agency Reporting System (CAARS) and Client Data Systems.
- E Provide EITHER Body Mass Index OR both Height and Weight
- F Provide for UP TO two informal supports, regardless of ADL or IADL
- G This field will be used in conjunction with date of birth and gender to identify duplication between counties.

CLIENT DATA SPECIFICATIONS - April 2013

Table #: 2

File Name: SERVICES.TXT

File Conter ACTUAL UNITS OF SERVICES PROVIDED

STATUS: REQUIRED FOR CLUSTER 1, CLUSTER 2, OTHER & CAREGIVER CLIENTS

Format: One record per service delivered per fund per client per quarter

SERVICE CLUSTER				Field Name	Length	Start Pos.	End Pos.	Codes or See Att. B
1	2	3	CG					
R	R	R	R	County Code	2	1	2	See Att. B Sec. A
R	R	R	R	Record Number/KEY*	10	3	12	Locally assigned
R	R	R	R	Period of Service (yyyymm)	6	13	18	Month & Year of service delivery
R	R	R	R	Service Code	3	19	21	See Att. B Sec. D
R	R	R	R	Funding Source	2	22	23	See Att. B Sec. E
R	R	R	R	Number of units provided	10	24	33	Format: 7 places,decimal point, 2 decimals numbers(9999999.99)
				Total	33			

* **Client's Record Number/KEY must remain the same each submission.**

EXAMPLES for South County (county code 75):

1 John Jones (Client ID # 088) received 21 home delivered meals from County MOW paid for under SNAP, and 14 1/4 hours of Housekeeping/Chore from Catholic Family Services through EISEP funding during April - June, 2000

2 Mary Smith (Client ID #245) received 12 congregate meals from the South County Meals Program through Title III funding and 10 units of transportation from the ABC Bus Service funded through CSE during April-June, 2000

Data records to be submitted:

CLIENT DATA SPECIFICATIONS - April 2013

Table #: 3
 File Content: ADL/IADL Status of Clients
 Format: One record per client

File Name: ADLIADL.TXT
 STATUS: REQUIRED FOR **CLUSTER 1 CLIENTS ONLY**

Field Name	Length	Start Pos.	End Pos.	Codes or See Att. B
County Code	2	1	2	See Att. B Sec. A
Record Number/KEY	10	3	12	Locally assigned
IADL Type				
01=Housework/cleaning IADL Status	1	13	13	1=Totally Able 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
Is Need Met Currently (at time of Assessment)? If yes:	1	14	14	Y or T or 1; N or F or 2; blank = Unknown
a. Met with Formal Supports?	1	15	15	Y or T or 1; N or F or 2; blank = Unknown
b. Met with Informal Supports?	1	16	16	Y or T or 1; N or F or 2; blank = Unknown
02=Shopping IADL Status	1	17	17	1=Totally Able 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
Is Need Met Currently (at time of Assessment)? If yes:	1	18	18	Y or T or 1; N or F or 2; blank = Unknown
a. Met with Formal Supports?	1	19	19	Y or T or 1; N or F or 2; blank = Unknown
b. Met with InFormal Supports?	1	20	20	Y or T or 1; N or F or 2; blank = Unknown
03=Laundry IADL Status	1	21	21	1=Totally Able 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
Is Need Met Currently (at time of Assessment)? If yes:	1	22	22	Y or T or 1; N or F or 2; blank = Unknown
a. Met with Formal Supports?	1	23	23	Y or T or 1; N or F or 2; blank = Unknown
b. Met with InFormal Supports?	1	24	24	Y or T or 1; N or F or 2; blank = Unknown

CLIENT DATA SPECIFICATIONS - April 2013

Table #: 3
 File Content: ADL/IADL Status of Clients
 Format: One record per client

File Name: ADLIADL.TXT
 STATUS: REQUIRED FOR **CLUSTER 1 CLIENTS ONLY**

Field Name	Length	Start Pos.	End Pos.	Codes or See Att. B
04=Use transportation IADL Status	1	25	25	1=Totally Able 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
Is Need Met Currently (at time of Assessment)? If yes:	1	26	26	Y or T or 1; N or F or 2; blank = Unknown
a. Met with Formal Supports?	1	27	27	Y or T or 1; N or F or 2; blank = Unknown
b. Met with InFormal Supports?	1	28	28	Y or T or 1; N or F or 2; blank = Unknown
05=Prepare & cook meals IADL Status	1	29	29	1=Totally Able 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
Is Need Met Currently (at time of Assessment)? If yes:	1	30	30	Y or T or 1; N or F or 2; blank = Unknown
a. Met with Formal Supports?	1	31	31	Y or T or 1; N or F or 2; blank = Unknown
b. Met with InFormal Supports?	1	32	32	Y or T or 1; N or F or 2; blank = Unknown
07=Handle Personal business/finances IADL Status	1	33	33	1=Totally Able 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
Is Need Met Currently (at time of Assessment)? If yes:	1	34	34	Y or T or 1; N or F or 2; blank = Unknown
a. Met with Formal Supports?	1	35	35	Y or T or 1; N or F or 2; blank = Unknown
b. Met with InFormal Supports?	1	36	36	Y or T or 1; N or F or 2; blank = Unknown
08=Use Telephone IADL Status	1	37	37	1=Totally Able 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
Is Need Met Currently (at time of Assessment)?	1	38	38	Y or T or 1; N or F or 2; blank = Unknown

CLIENT DATA SPECIFICATIONS - April 2013

Table #: 3
 File Content: ADL/IADL Status of Clients
 Format: One record per client

File Name: ADLIADL.TXT
 STATUS: REQUIRED FOR **CLUSTER 1 CLIENTS ONLY**

Field Name	Length	Start Pos.	End Pos.	Codes or See Att. B
If yes:				
a. Met with Formal Supports?	1	39	39	Y or T or 1; N or F or 2; blank = Unknown
b. Met with InFormal Supports?	1	40	40	Y or T or 1; N or F or 2; blank = Unknown
16=Self-admin of medications				
IADL Status	1	41	41	1=Totally Able 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
Is Need Met Currently (at time of Assessment)?	1	42	42	Y or T or 1; N or F or 2; blank = Unknown
If yes:				
a. Met with Formal Supports?	1	43	43	Y or T or 1; N or F or 2; blank = Unknown
b. Met with InFormal Supports?	1	44	44	Y or T or 1; N or F or 2; blank = Unknown
ADL Type				
09=Bathing				
ADL Status	1	45	45	1=Totally Able 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
Is Need Met Currently (at time of Assessment)?	1	46	46	Y or T or 1; N or F or 2; blank = Unknown
If yes:				
a. Met with Formal Supports?	1	47	47	Y or T or 1; N or F or 2; blank = Unknown
b. Met with InFormal Supports?	1	48	48	Y or T or 1; N or F or 2; blank = Unknown
10=Personal Hygiene				
ADL Status	1	49	49	1=Totally Able 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
Is Need Met Currently (at time of Assessment)?	1	50	50	Y or T or 1; N or F or 2; blank = Unknown
If yes:				
a. Met with Formal Supports?	1	51	51	Y or T or 1; N or F or 2; blank = Unknown
b. Met with InFormal Supports?	1	52	52	Y or T or 1; N or F or 2; blank = Unknown

CLIENT DATA SPECIFICATIONS - April 2013

Table #: 3
 File Content: ADL/IADL Status of Clients
 Format: One record per client

File Name: ADLIADL.TXT
 STATUS: REQUIRED FOR **CLUSTER 1 CLIENTS ONLY**

Field Name	Length	Start Pos.	End Pos.	Codes or See Att. B
11=Dressing				
ADL Status	1	53	53	1=Totally Able 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
Is Need Met Currently (at time of Assessment)?	1	54	54	Y or T or 1; N or F or 2; blank = Unknown
If yes:				
a. Met with Formal Supports?	1	55	55	Y or T or 1; N or F or 2; blank = Unknown
b. Met with InFormal Supports?	1	56	56	Y or T or 1; N or F or 2; blank = Unknown
12=Mobility				
ADL Status	1	57	57	1=Totally Able 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
Is Need Met Currently (at time of Assessment)?	1	58	58	Y or T or 1; N or F or 2; blank = Unknown
If yes:				
a. Met with Formal Supports?	1	59	59	Y or T or 1; N or F or 2; blank = Unknown
b. Met with InFormal Supports?	1	60	60	Y or T or 1; N or F or 2; blank = Unknown
13=Transfer				
ADL Status	1	61	61	1=Totally Able 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
Is Need Met Currently (at time of Assessment)?	1	62	62	Y or T or 1; N or F or 2; blank = Unknown
If yes:				
a. Met with Formal Supports?	1	63	63	Y or T or 1; N or F or 2; blank = Unknown
b. Met with InFormal Supports?	1	64	64	Y or T or 1; N or F or 2; blank = Unknown
14=Toileting				
ADL Status	1	65	65	1=Totally Able 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
Is Need Met Currently (at				

CLIENT DATA SPECIFICATIONS - April 2013

Table #: 3
 File Content: ADL/IADL Status of Clients
 Format: One record per client

File Name: ADLIADL.TXT
 STATUS: REQUIRED FOR **CLUSTER 1 CLIENTS ONLY**

Field Name	Length	Start Pos.	End Pos.	Codes or See Att. B
time of Assessment)?	1	66	66	Y or T or 1; N or F or 2; blank = Unknown
If yes:				
a. Met with Formal Supports?	1	67	67	Y or T or 1; N or F or 2; blank = Unknown
b. Met with InFormal Supports?	1	68	68	Y or T or 1; N or F or 2; blank = Unknown
15=Eating				
ADL Status	1	69	69	1=Totally Able 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
Is Need Met Currently (at time of Assessment)?	1	70	70	Y or T or 1; N or F or 2; blank = Unknown
If yes:				
a. Met with Formal Supports?	1	71	71	Y or T or 1; N or F or 2; blank = Unknown
b. Met with Informal Supports?	1	72	72	Y or T or 1; N or F or 2; blank = Unknown
Total Number of ADL**	1	73	73	
Total Number of IADL**	1	74	74	

Total 74
 * Client's Record Number/KEY must remain the same each submission.

****The client must have a status of 2, 3, 4 to be counted.**

IADL	ADL
01=Housework/cleaning	09=Bathing
02=Shopping	10=Personal Hygiene
03=Laundry	11=Dressing
04=Use transportation	12=Mobility
05=Prepare & cook meals	13=Transfer
07=Handle Personal business/finances	14=Toileting
08=Use Telephone	15=Eating
16=Self-admin of medications	

CLIENT DATA SPECIFICATIONS - April 2013

Table #: 4

File Conter CLIENT CHARACTERISTICS

Format: One record per characteristic per client

File Name: CHARACTERISTICS.TXT

STATUS: REQUIRED FOR **CLUSTER 1 CLIENTS ONLY**

		Length	Start Pos.	End Pos.	
R	County Code	2	1	2	See Att. B Sec. A
R	Record Number/KEY*	10	3	12	Locally assigned
R	Characteristic Code	3	13	15	See Att. B Sec. F
	Total	15			

* **Client's Record Number/KEY must remain the same each submission.**

EXAMPLES for South County (county code 75):

- 1 John Jones (Client ID # 088) uses a walker and has a hearing aid because of his serious hearing impairment; he also has high blood pressure, is significantly dehydrated and frequently suffers from depression.

Data records to be submitted for this client:

countycode clientID characteristic code

```
75 0000000088 002
75 0000000088 004
75 0000000088 099
75 0000000088 167
75 0000000088 199
75 0000000088 177
```

CLIENT DATA SPECIFICATIONS - April 2013

Table #: 5
 File Content: HEALTH EVENTS
 Format: One record per event per client

File Name: HEALTHEVENTS.TXT
 STATUS: REQUIRED FOR **CLUSTER 1 CLIENTS ONLY**

		Length	Start Pos.	End Pos.	
R	County Code	2	1	2	See Att. B Sec. A
R	Record Number/KEY*	10	3	12	Locally assigned
R	Health event category	2	13	14	For Health Event Category Use: 01=Hospital visit 02=Emergency Room 03=PRI 04=DMS-1 05=Physician Visit 06=Clinic 09=Other
R	Date of event (mm/dd/yyyy)	10	15	24	
	Total	24			

* Client's Record Number/KEY must remain the same each submission.

00=No Event

CLIENT DATA SPECIFICATIONS - April 2013

Table #: 6

File Conter CARE PLAN SERVICES**

Format: One record per service per client

File Name: CAREPLANS.TXT

STATUS: REQUIRED FOR CLUSTER 1 CLIENTS ONLY

		Length	Start Pos.	End Pos.	
R	County Code	2	1	2	See Att. B Sec. A
R	Record Number/KEY*	10	3	12	Locally assigned
R	Service code	3	13	15	See Att. B Sec. D
R	Number of Units of Service (>0)	3	16	18	
R	Frequency Period	1	19	19	W or 2 = Weekly; M or 3 = Monthly O or 4 = Services only delivered as needed
	Has client been placed on waiting list for this service?	1	20	20	Y or T or 1; N or F or 2; blank = Unknown
R	Care Plan Acceptance Date (mm/dd/yyyy)**	10	21	30	
R	Client is Self directing/able to direct	1	31	31	Y or T or 1; N or F or 2; blank = Unknown
	Total	31			

* Client's Record Number/KEY must remain the same each submission.

** Use most current care plan. Note only one care plan per client covering all services. Care plans created for individual services do not get reported.

CLIENT DATA SPECIFICATIONS - April 2013

Table #: 7 File Name: Caregivers.txt
 File Content: CAREGIVERS FOR ELDERLY AND GRANDPARENT
 Format: One record per relationship

SERVICE CLUSTER	GENERAL CLIENT INFORMATION			Start Pos.	End Pos.	
		Length				
R	County Code	2	1	2	See Att. B Sec. A	
R	Record Number/KEY*	10	3	12	Locally Assigned	
R	Type	1	13	13	C=Caregiver G=Grandparent	
R	Relationship	1	14	14	For C aregiver use:	0=Unknown\Missing 1=Husband 2=Wife 3=Son/Son-in-law 4=Daughter/Daughter-in-law 5=Other Relative 6=Non-Relative
					For G randparent use:	0=Unknown\Missing 1=Grandparents 2=Other Elderly Relative 3=Other Elderly Non-Relative
	Total	14				

* Client's Record Number/KEY must remain the same each submission.

CLIENT DATA SPECIFICATIONS - April 2013

Table #: 8

File Name: ELDERABUSE.TXT

File Conter ELDER ABUSE CONTACTS

Format: Multiple categories per client

STATUS: A record is required for each report of abuse. If the client exists within the system, all fields are required. If the client does not exist, the use the anonymous key of 9999999980 or include in NYConnects report.

SERVICE CLUSTER				Field Name	Length	Start Pos.	End Pos.	
1	2	3	CG					
R				County Code	2	1	2	See Att. B Sec. A
R				Record Number/KEY*	10	3	12	Locally assigned
R				Contact Month (yyyymm)	6	13	18	
R				Elder Abuse Category	2	19	20	01=Physical Abuse 02=Sexual Abuse 03=Emotional Abuse 04=Financial Exploitation 05=Active and Passive Neglect 06=Self Neglect 07=Domestic Violence 00=Other (e.g. Abandonment)
R	R	R	R	Referred to	2	21	22	01=Adult Protective Services 02=Police Agency 03=Domestic Violence Service Provider 04=AAA 05=Other 06=Not Referred
				Total	22			

* Client's Record Number/KEY must remain the same each submission.

ATTACHMENT B
April 2013
CODING STRUCTURE
FOR USE BY AAAs IN CODING ELECTRONIC CLIENT FILES

A. COUNTY CODES

Albany	01	Onondaga	31
Allegany	02	Ontario	32
Broome	03	Orange	33
Cattaraugus	04	Orleans	34
Cayuga	05	Oswego	35
Chautauqua	06	Otsego	36
Chemung	07	Putnam	37
Chenango	08	Rensselaer	38
Clinton	09	Rockland	39
Columbia	10	St. Lawrence	40
Cortland	11	Saratoga	41
Delaware	12	Schenectady	42
Dutchess	13	Schoharie	43
Erie	14	Schuyler	44
Essex	15	Seneca	45
Franklin	16	Steuben	46
Fulton	17	Suffolk	47
Genesee	18	Sullivan	48
Greene	19	Tioga	49
Herkimer	21	Tompkins	50
Jefferson	22	Ulster	51
Lewis	23	Warren/Hamilton	52
Livingston	24	Washington	53
Madison	25	Wayne	54
Monroe	26	Westchester	55
Montgomery	27	Wyoming	56
Nassau	28	Yates	57
Niagara	29	NYC	60
Oneida	30	Seneca Nation of Indians	62
		St. Regis-Mohawk	63

B. STATUS / SUB-STATUS

Status: 1- Active
2- Inactive or Terminated

Sub-status:

if Status =1, use Sub-status Code 20 or 35

20 = Case Managed

35= Non Case Managed

if Status =2, use the following Sub-status Codes

For clients changing status from active to terminated/inactive.*

Use the following sub-status codes to record primary reason for terminating services or becoming inactive.

01 - None (Reason Unknown)

02 - Nursing Facility

08 - Assisting Living

05 - Moved

06 - Died

07 - Other (Reason not listed)

14 - Client refuse service, assessment or reassessment (Includes 15 - Refused assessment and 16 - Refused reassessment).

17 - Medicaid Home Care eligible

23 - Unable to serve due to appropriateness issue (client changes in behavior, mental, cognitive, or physical status - no longer appropriate for receiving aging network services, but still live in community).

24 - Unable to serve due to accessibility issue - Note: accessibility issues include for example, workers or services are not able to reach the client or the client is not able to access the services, e.g., no transportation. (This category includes: 12 - No response, 18 - Not in service area, 19 - No contact, 21-worker safety, and 22-transportation unavailable).

25 - Unable to serve due to eligibility issue (This category includes: 11 - age, and 34 - other eligibility issues).

33 - Client no longer needs service - Client improved and or goals have been met.

36 - Services are substituted by other helping resources (formal/informal) in the community and not due to appropriate, accessibility, or eligibility issue.

Following codes have been eliminated; 03 - Non-Payment, 04 - Service Complete, 31 - Requested by Client, 32 – Refused to apply for Medicaid.

* Terminated/Inactive: clients have not used any aging network services for more than 12 consecutive months.

C. RELATIONSHIP

53 - Agency	24 - Mother-in-law
52 - Agent	41 - Neighbor
05 - Aunt	49 - Nephew
03 - Brother	48 - Niece
60 - Brother-in-law	72 - None Exists
62 - CHHA	55 - Officials
14 - Cousin	13 - Other
50 - Daughter-in-law	54 - Owner
08 - Daughter	56 - Relative
45 - Doctor	67 - Religious Org.
69 - Domestic Partner	40 - Self
71 - Family	04 - Sister
02 - Father	61 - Sister-in-law
23 - Father-in-law	68 - Social Service Agency
43 - Friend	47 - Social Worker
19 - Granddaughter	07 - Son
09 - Grandfather	16 - Stepdaughter
10 - Grandmother	17 - Stepfather
20 - Grandson	18 - Stepmother
65 - Hospital	15 - Stepson
12 - Husband	44 - Super
51 - Son-in law	06 - Uncle
42 - Landlord	46 - Visiting Nurse
66 - Medicaid	11 - Wife
01 - Mother	

D – SERVICES

Code	Service	Code	Service
905	Access Assistance ⁵	906	Information Services
510	Adult Day Services	301	Legal Services
504	Assisted Transport	502	Nutrition Counseling
527	Caregiver Services	501	Nutrition Education
505	Case Management	601	Other Services General
206	Consumer Directed In-Home Services	602	Other Services IIIE Respite
403	Congregate Ineligible Meals ⁶	603	Other Services IIIE Supplemental
402	Congregate Meals	604	Other Services IIIE Information
902	Counseling/Support Groups/Training ⁵	102	Outreach
512	Health Promotion Services	509	PERS
401	Home Delivered Meals	205	Personal Care Level I ³
404	Home Delivered Ineligible Meals ⁶	202	Personal Care Level II ⁴
201	Home Health Aide	903	Respite Care ⁵
526	In Home Contact & Support ¹	519	Senior Center Rec. & Ed
103	Information & Assistance ²	904	Supplemental Services ⁵
		101	Transportation

- 1 Includes Friendly Visiting, Shopping Assistance, Supervision Level NIR, and Telephone Reassurance
- 2 Includes Case Assistance, Counseling, Health Insurance Counseling, and Housing Assistance
- 3 Personal Care Level I = Housekeeping/Chore
- 4 Personal Care Level II = Homemaking/Personal Care
- 5 Title III-E Caregiver Services (Caregivers serving the elderly/Grandparents serving children) only
- 6 Use to code meals that are ineligible and for consumers who are otherwise eligible

E. CLIENT TYPES/FUNDING SOURCES

05 - OTHER	13 - III-C-1	18 - Title V	23 - WRAP	31 – Veterans Program
07 - SNAP	14 - III-C-2	19 - TITLE III-B	24 – NYConnects*	32 - MIPPA
09 - EISEP	15 – III-D	20 - III-E Grandparent	27 – ARRA****	33- Informal***
10 - CSE	16 - III-E Caregiver	21 - HIICAP	29 - LTHHCP	
12 - CSI	17 - HEAP	22 - LTCIEOP	30 - Medicaid**	

* Previously labeled PoE

** Medicaid-funded, non-LTHHCP “Medicaid Service Coordination” (MSC) program.

*** Informal is used when necessary, to record those services delivered as an informal support.

****The ARRA Program has ceased.

F. CHARACTERISTICS INFORMATION (*Where there is none please use 000*)

Assistive Devices (1)

965 Accessible vehicle	006 Eyeglasses
966 Bed rail	004 Hearing Aid
001 Cane	008 Other
003 Dentures	002 Walker

Chronic Illness (2)

159 Alcoholism	952 HIV/AIDS
010 Alzheimer's	200 High Cholesterol
160 Anemia	180 Hyperglycemia
174 Anorexia	943 Hypoglycemia
096 Arthritis	406 Incontinence
098 Cancer	958 Legally blind
969 Cellulitis	168 Liver disease
161 Chronic constipation	181 Low blood pressure
175 Chronic diarrhea	169 Osteoporosis
953 Chronic obstructive pulmonary disease (COPD)	402 Other
954 Chronic pain	959 Oxygen dependent
162 Colitis	960 Paralysis
176 Colostomy	102 Parkinson's
163 Congest heart failure	961 Pernicious anemia
955 Decubitus ulcers	170 Recent fractures
956 Developmental Disabilities	182 Renal disease
101 Diabetes	103 Respiratory problems
957 Dialysis	962 Shingles
178 Diverticulitis	183 Smelling impairment
201 Frequent Falls	171 Speech problems
165 Gall bladder disease	963 Traumatic brain injury
099 Hearing impairment	104 Stroke
166 Heart disease	964 Tremors
179 Hiatal hernia	173 Ulcer
167 High blood pressure	185 Urinary Tract infection

Cognitive Status (3)

020 Alert	027 Impaired decision making
190 Appears lonely	026 Memory deficit
021 Cooperative	271 Other
270 Dementia	023 Physical aggression
199 Depressed	028 Problem behavior reported
030 Diagnosed mental health problem	967 Self-neglect
024 Disruptive socially	187 Sleeping problems
029 Evidence of substance abuse	968 Suicidal behavior
025 Hallucinations	189 Suicidal thoughts
188 History of mental health treatment	022 Verbal disruption

Nutrition Problems (4)

014 Appetite	017 Dental Problems
016 Chewing/Swallowing	015 Digestive Problems
177 Dehydration	403 Other

Primary Language (5)

946 Chinese	951 Other
949 French\Haitian Creole	947 Russian
948 Italian	945 Spanish
950 Korean	

G. CODING FOR USE IN IDENTIFYING NON-REGISTERED PARTICIPANTS IN CLIENT AND SERVICE FILES

In the record number/key field which is 10 characters long:

• Elder Abuse	Each contact	9999999980 as the record number/key
• III-E Assistance	Each event/activity	9999999982 as the record number/key
• Other Services General (601)	Each event/activity	9999999983 as the record number/key
• Other Services III-E Information (604)	Each event/activity	9999999984 as the record number/key
• In-Home Contact & Support	Each contact	9999999985 as the record number/key
• Sr. Center Recreation/Education	One group session	9999999986 as the record number/key
• Health Promotion	Each Participant	9999999987 as the record number/key
• Personal Emergency Response (PERS)	One unit	9999999988 as the record number/key
• Caregiver Services	Each Participant	9999999989 as the record number/key
• USDA eligible seniors, spouses, disabled persons living in Senior Housing	Each meal	9999999990 as the record number/key
• Guests/staff under 60 & other ineligible	Each meal	9999999991 as the record number/key
• USDA eligible volunteers	Each meal	9999999992 as the record number/key
• Information & Assistance	Each contact	9999999993 as the record number/key
• Food handlers	Each meal	9999999994 as the record number/key
• Transportation	One Way Trip	9999999995 as the record number/key
• Legal	One hour	9999999996 as the record number/key
• Outreach (Including III-E)	Each contact	9999999997 as the record number/key
• Nutrition Education	Each Participant	9999999998 as the record number/key

9999999999 code reserved for NY Connects data use.

*Use for Other Services: 601 and 604.

To illustrate the coding above, it may be helpful to look at an example of a July picnic funded by CSE in County 75 that included 16 senior guests. The **client record** would have the county code (75) and special record key (9999999990) and nothing else. The **service record** would show:

Service Record

County code	75
Record number/key	9999999990
Period of service	200207
Service code	402
Funding source	10
Number of units	0000016.00

Client Record

County code	75
Record number/key	9999999990

H. CODING FOR USE IN IDENTIFYING NATION OF ORGIN

001	Afghan	034	Cameroonian	066	Gambian
002	Albanian	035	Canadian	067	Georgian
003	Algerian	036	Cape Verdean	068	German
004	American	037	Central African	069	Ghanaian
005	Andorran	038	Chadian	070	Greek
006	Angolan	039	Chilean	071	Grenadian
007	Antiguans	040	Chinese	072	Guatemalan
008	Argentinean	041	Colombian	073	Guinea-Bissauan
009	Armenian	042	Comoran	074	Guinean
010	Australian	043	Congolese	075	Guyanese
011	Austrian	044	Costa Rican	076	Haitian
012	Azerbaijani	045	Croatian	077	Herzegovinian
013	Bahamian	046	Cuban	078	Honduran
014	Bahraini	047	Cypriot	079	Hungarian
015	Bangladeshi	048	Czech	080	I-Kiribati
016	Barbadian	049	Danish	081	Icelander
017	Barbudans	050	Djibouti	082	Indian
018	Batswana	051	Dominican	083	Indonesian
019	Belarusian	052	Dutch	084	Iranian
20	Belgian	053	East Timorese	085	Iraqi
021	Belizean	054	Ecuadorean	086	Irish
022	Beninese	055	Egyptian	087	Israeli
023	Bhutanese	056	Emirian	088	Italian
024	Bolivian	057	Equatorial Guinean	089	Ivorian
025	Bosnian	058	Eritrean	090	Jamaican
026	Brazilian	059	Estonian	091	Japanese
027	British	060	Ethiopian	092	Jordanian
028	Bruneian	061	Fijian	093	Kazakhstani
029	Bulgarian	062	Filipino	094	Kenyan
030	Burkinabe	063	Finnish	095	Kittian and Nevisian
031	Burmese	064	French	096	Kuwaiti
032	Burundian	065	Gabonese	097	Kyrgyz
033	Cambodian	066	Gambian	098	Laotian

099	Latvian	132	North Korean	165	South Korean
100	Lebanese	133	Northern Irish	166	Spanish
101	Liberian	134	Norwegian	167	Sri Lankan
102	Libyan	135	Omani	168	Sudanese
103	Liechtensteiner	136	Pakistani	169	Surinamer
104	Lithuanian	137	Palauan	170	Swazi
105	Luxembourger	138	Panamanian	171	Swedish
106	Macedonian	139	Papua New Guinean	172	Swiss
107	Malagasy	140	Paraguayan	173	Syrian
108	Malawian	141	Peruvian	174	Taiwanese
109	Malaysian	142	Polish	175	Tajik
110	Maldivan	143	Portuguese	176	Tanzanian
111	Malian	144	Qatari	177	Thai
112	Maltese	145	Romanian	178	Togolese
113	Marshallese	146	Russian	179	Tongan
114	Mauritanian	147	Rwandan	180	Trinidadian or Tobagonian
115	Mauritian	148	Saint Lucian	181	Tunisian
116	Mexican	149	Salvadoran	182	Turkish
117	Micronesian	150	Samoan	183	Tuvaluan
118	Moldovan	151	San Marinese	184	Ugandan
119	Monacan	152	Sao Tomean	185	Ukrainian
120	Mongolian	153	Saudi	186	Uruguayan
121	Moroccan	154	Scottish	187	Uzbekistani
122	Mosotho	155	Senegalese	188	Venezuelan
123	Motswana	156	Serbian	189	Vietnamese
124	Mozambican	157	Seychellois	190	Welsh
125	Namibian	158	Sierra Leonean	191	Yemenite
126	Nauruan	159	Singaporean	192	Zambian
127	Nepalese	160	Slovakian	193	Zimbabwean
128	New Zealander	161	Slovenian	200	Reported Multiple
129	Nicaraguan	162	Solomon Islander		
130	Nigerian	163	Somali		
131	Nigerien	164	South African		

NOTES:

For data elements, the following designations are used in the file specifications to note whether the information is required:

R Required for either NAPIS reporting or NYSOFA management/advocacy
 M Information is used for NYSOFA monitoring, management and advocacy activities.

Code	Program	Abbrev.
05	All Other Program Administered by the AAA	OTHER
07	Supplemental Nutrition Assistance Program	SNAP
09	Expanded In-home Services for the Elderly Program	EISEP
10	Community Services for the Elderly Program	CSE
12	Congregate Services Initiative	CSI
13	Title III-C-1 of the Older Americans Act of 1965 as Amended	III-C-1
14	Title III-C-2 of the Older Americans Act of 1965 as Amended	III-C-2
15	Title III-D of the Older Americans Act of 1965 as Amended	III-D
16	Title III-E of the Older Americans Act of 1965 as Amended	III-E Caregiver
17	Home Energy Assistance Program	HEAP
18	Title V of the Older Americans Act of 1965 as Amended	V
19	Title III-B of the Older Americans Act of 1965 as Amended	III-B
20	Title III-E of the Older Americans Act of 1965 as Amended	III-E Grandparent
21	Health Insurance Information Counseling Program	HIICAP
22	Long Term Care Insurance Education and Outreach Program	LTCIEOP
23	Weatherization Referral and Packaging	WRAP
24	NY Connects (Point of Entry)	POE
27	American Recovery and Reinvestment Act	ARRA
29	Long Term Home Health Care Program	LTHHCP
30	Provides financial assistance for medical expenses of individual needy citizens	Medicaid
31	Veterans Directed Services Program	Veterans
32	Medicare Improvements for Patients and Providers Act	MIPPA
33	Services delivered through an informal support process,	Informal

Sample NAPIS Client Registration Form

New York State Office for the Aging

Use a medium black pen and keep letters and number in the boxes. Fill in circles completely and use an X instead of checkmarks. Note social security number is not required.

PROVIDER ID: <input type="text"/> - <input type="text"/>		Intake Date: <input type="text"/> /	
CLIENT INFORMATION:		Gender: <input type="radio"/> Male <input type="radio"/> Female	DOB: <input type="text"/> - <input type="text"/> - <input type="text"/>
		Veteran: <input type="radio"/> Yes <input type="radio"/> No	
Last Name: <input type="text"/>		First Name: <input type="text"/>	
Mid Init <input type="text"/>			
Address: <input type="text"/>			
City: <input type="text"/>		St: <input type="text"/>	Zip + 4: <input type="text"/> - <input type="text"/>
Co: <input type="text"/>			
Phone: (<input type="text"/>) <input type="text"/> - <input type="text"/>		Living Status: <input type="checkbox"/> 1=Alone, 2=With Spouse Only, 3=With relatives, 4=With non-relatives, 5=With Spouse and others, 6=Others	
Marital Status: <input type="radio"/> Married <input type="radio"/> Widowed <input type="radio"/> Divorced <input type="radio"/> Never Married		Number in Household: <input type="text"/>	Ethnicity: <input type="radio"/> Hispanic <input type="radio"/> Non-Hispanic
Race: <input type="radio"/> White <input type="radio"/> Black <input type="radio"/> American Indian/Alaskan Native <input type="radio"/> Asian <input type="radio"/> Native Hawaiian/Pacific Islander <input type="radio"/> Other Race <input type="radio"/> 2 or More Races <input type="radio"/> White (Alone) <input type="radio"/> Hispanic			
Income Status: (Below Poverty Level) 100% <input type="radio"/> Yes <input type="radio"/> No 150% <input type="radio"/> Yes <input type="radio"/> No		Frail/Disabled: <input type="radio"/> Yes <input type="radio"/> No	
Emergency Contact: <input type="text"/>		Phone: (<input type="text"/>) <input type="text"/> - <input type="text"/>	
SERVICES INFORMATION:		Limited English Proficiency: <input type="checkbox"/> Primary Language: _____	
Cluster II Services <input type="checkbox"/> Congregate Meals <input type="checkbox"/> Nutrition Counseling <input type="checkbox"/> Assisted Trans.		Cluster III Services <input type="checkbox"/> Info & Referral <input type="checkbox"/> Legal Services <input type="checkbox"/> Transportation <input type="checkbox"/> Nutrition Education <input type="checkbox"/> Outreach <input type="checkbox"/> Other	
Determining Nutritional Health			
Read the statements below. Circle the number in the "YES" column for those that apply to you or someone you know. For each answer, score that number in the box. Total your nutritional score and compare below.			
			YES
I have an illness/condition that made me change the kind/amount of food I eat.			2
I eat fewer than 2 meals a day.			3
I eat few fruits or vegetables, or milk products.			2
I have 3 or more drinks of beer, liquor or wine almost every day.			2
I have tooth or mouth problems that make it hard for me to eat.			2
I don't always have enough money to buy the food I need.			4
I eat alone most of the time.			1
I take 3 or more different prescribed or over-the-counter drugs a day.			1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.			2
I am not always physically able to shop, cook and/or feed myself.			2
TOTAL			
A score of 0-2 means Good, recheck at six months.			
A score of 3-5 means you are at moderate nutritional risk and need to see what you can do to improve eating habits and make life-style changes.			
A score of 6 or more means you are at a high nutritional risk. Take the checklist to a doctor, dietitian or qualified health or social service professional and talk to them. Ask for definite ways to improve your nutritional health.			

Attachment K
CAARS\Client\Verified\Plan Reports 2013

Quarterly Units of Service Report (11) – There is a one page report for each county and a one page statewide report. Reported units of service are compared to units of service projected in the AIP to determine if the units reported are a reasonable percent of those projected for the time period.

Error Checks (30) – Checks data by period for errors involving fiscal data (CAARS quarterly report).

Title V Expenditure Report (31) – A one page report listing all counties and showing Totals for Federal expenditures, Admin. Enrollee Wages and Other Costs.

Summary of Expenditures (32A) - Expenditure information by service and funding stream. There is a one page report for each county and a one page Statewide.

Comparison of Expenditures and Revenues (32B) - An individual three page report for each funding stream showing all counties.

Summary of Expenditures (32C) - Expenditure information by service and funding stream. There is a one page report for each county which provides percent of projected expended and a one page Statewide.

EISEP Status Report (33) – This three page report shows EISEP data for units, expenditures, persons served, etc.

Quarterly Meal Units Report (35A) – This is a two page report for congregate meals which compares two quarters and shows percent of change.

Quarterly Meal Cost Report (35B) – This two page report lists area agencies by size. Unit cost for Home Delivered Meals and Congregate meals are calculated by dividing the total expenditures by total units.

QUARTERLY STATUS REPORT - Demographic Information (36A) - This is a one page report for each county. A statewide report is also available. This report shows the total persons served by program and in total and includes projections and actual and counts for ethnic\racial characteristics.

Quarterly Status Report (36B) (Expenditure information page 2) Note: Expenditure information is generated from the grants database and is for the program quarter which is noted below the funding source.

Units and Expenditures (39A) – This one page report summarizes unit cost by funding stream for Transportation, Personal Care Level II, Personal Care Level I, Home Delivered Meals, Congregate Meals, Case Management and Adult Day Services. The report helps readers to determine if units of service reasonably are spread across funding streams.

Quarterly Summary of Unit Costs (39B) – This report is the same as above but shows data by funding source.

Comparison of Costs Per Unit Budgeted vs. Reported (39C) - Report compares AIP data to reported CAARS data and shows the percent of variance. Required action is also indicated.

Budgeted vs. Actual Title V Expenditures (41) – by quarter showing total for year and percent of actual budgeted.

Title III-E Summary Report (42) – Report provides information on Caregivers and the services they receive.

Cost Per Service/Client (43) - Report provides an overall picture of number of clients, units and expenditures for each service with an average cost per unit and client.

Total Served Comparison Report (44) – Allows user to compare multiple years.

Estimated Allocations (61) - Information is gathered for this report from the resource allocation pages of the plan (this information may be revised by budget mod or letter to ASR). This information is used on the CAARS 11, 33 and 36 reports to compare projected versus reported data.

Reported and Actual Expenditures (81) - Available after budget closeout and compares CAARS expenditures to voucher data showing details by county.

Verified Data Reports

Two Year Client Count Comparison (36D) – this one page report shows number of people served for selected programs and services. The report uses verified data and allows users to make two year count comparison.

Two Year Service Data Comparison (36E) – this one page report have people, units, expenditures data for major aging network services. The report uses verified data and allows users to make two year count comparison.

Verified NSIP Congregate Meals (35A) - The report used verified congregate meals data, compares two quarters, shows percent of change between quarters, and yearend total.

Verified NSIP Home Delivered Meals (35A) - The report used verified home delivered meals data, compares two quarters, shows percent of change between quarters, and yearend total.

Verified Title III-E Summary (42) – Report uses IIIE verified counts, provides information on Caregivers and the services they receive.

Verified Cost Per Service/Client (43) - Report uses verified Client Unit counts, provides an overall picture of number of clients, units and expenditures for each service with an average cost per unit and client.

Client Data Reports

Client Unit Data Comparison Report – (ClientDataVsVerifiedData) – Compares reported data for persons served and units provided with yearend AAA submitted verification. Allows users to see what is actually reported and compare it to the totals they have verified.

NAPIS Data Review – This report shows the total number of persons served by service. It also shows for the registered services the percent of data missing for selected required fields.

Title IIIE Client Unit Comparison Report – Compare IIIE reported data for persons served and units provided with AAA year end submitted verified data. Allow users to see what is actually reported and compare it to the numbers they have verified.

Missing Caregiver Relationships – **Title IIIE group 1 clients** are required to report Relationship data. Some clients have IIIE group 1 service records but do not have relationship record reported to us. This report is to identify IIIE group 1 client recordkey with missing relationship record.

Missing ADL/IADL Records – this type of missing occurs when **clients received cluster 1** services but do not report ADL IADL record. This report is for identifying client recordkey with this type of missing.

Missing Characteristics Records – the missing occurs when **clients received cluster 1** services but do not have health characteristics record reported. This report is to identify client recordkey with this type of missing.

Missing Health Events Records – this type of missing occurs when **clients received cluster 1** services but do not report Health Events record. This report is to identify client recordkey with this type of missing.

Missing Care Plans – this type of missing occurs when **clients received cluster 1** services but do not report Care Plan record. This report is for identifying client recordkey with this type of missing.

Plan Reports

AIP/4 Year Plan Narratives – Provides users with a way of printing out narrative and Attachment sections of the AIP/4 Year Plan.

End of Year AIP Variance Report – Compares AIP data with end of year CAARS data. Each county report is 10 pages.

Subcontractor Services – Information for each subcontractor entered into the system is reflected in this report.

Attachment L
Examples of Case Managed and Non Case Managed Clients
Numbers in brackets are for NYSOFA use.

Case Management is a comprehensive process that helps older persons with diminished functioning capacity, and/or their caregivers, gain access to and coordinate appropriate services, benefits and entitlements. Case management consists of assessment and reassessment, care planning, arranging for services, follow-up and monitoring with a contact at least once every two months and discharge. These activities must be provided by or under the direction of the designated case manager or case manager supervisor.

In each of the examples the client will receive units of case management for the time spent doing the assessment.

Example 1

The AAA gets a call that Bob, an elderly tenant has suffered a stroke and is having trouble taking care of himself. The AAA makes contact and a complete MDS assessment is done. The proposed care plan calls for daily home delivered meals and 3 hours per week of Personal Care Level 1. Bob accepts the care plan and signs the EISEP financial agreement. He will be a case managed client and receive at a minimum a contact every two months and a reassessment every year.

In this case Bob would be reported as an Active (1) Case Managed Client (20) client. MDS required assessment data must be entered and maintained. Units of case management can be reported for the time spent doing the assessment.

Example 2

Bobbie Jo calls the AAA and says she has severe arthritis and is confined to her home. Her arthritis makes cooking difficult. A complete MDS assessment is done and the assessor finds that she is able to take care of most daily activities but is unable to cook. Bobbie Jo accepts the proposed care plan calling for daily home delivered meals. Since this is the only service she will be receiving, she will not be case managed. She will be reassessed every year and have a six month contact as defined in 97-PI-20.

In this case Bobbi Jo would be reported as an Active (1) Non Case Managed Client (35). MDS required assessment data must be entered and maintained. Units of case management can be reported for the time spent doing the assessment.

Example 3

An outreach contact identifies Tom as a potential client. An assessment is begun but it quickly determined that Tom does not need any in-home services. Tom does however become a client for transportation, legal and congregate meals.

In this case Tom would be reported as an Active (1) Non Case Managed Client (35). No MDS required assessment data need be entered although information shown on the Sample NAPIS Client Registration Form would still need to be entered. Units of case management could be reported for the time spent doing the assessment.

Example 4

A hospital discharge planner contacts the AAA to say that Ya-Lin has been released from the hospital and sent home. The planner believes that Ya-Lin may require assistance. The AAA makes contact and Ya-Lin says that she is 70 years of age and due to her recent surgery, is unable to cook or leave her home. The AAA arranges for home delivered meals to be provided and schedules an assessment to be done in ten days. On day nine, Ya-Lin contacts the AAA and notifies them that she is mobile and cancels the service and assessment visit.

In this case Ya-Lin would be reported as an Inactive (2) Client refuse service (14). The meals provided will be reported. If enough information was collected and entered to create a unique client ID, If there was not enough information collected to create a unique ID meals would still be reported anonymously.

Example 5

A hospital discharge planner contacts the AAA to say that Ann has been released from the hospital and sent home. The planner believes that Ann may require assistance. The AAA makes contact and Ann agrees to be assessed. Midway through the assessment Ann tells the assessor that she is not interested in receiving any of the services offered.

In this case Ann would be reported as an Inactive (2) Client refuse service (14). Units of case management would be reported for the time spent doing the assessment.