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

TECHNICAL ASSISTANCE MEMORANDUM	**Number 16-TAM-02**
	Supersedes
	Expiration Date

DATE: July 26, 2016

TO: Area Agencies on Aging Directors and Peer Place Champions

SUBJECT: Statewide Client Data System Transition for Go-Dark and Post Go-Live

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PURPOSE: The purpose of this Technical Assistance Memorandum (TAM) is to provide helpful information for the "Go-Dark" and the Post "Go-Live" periods of the new Statewide Client Data System.

BACKGROUND: The New York State Office for the Aging has contracted with PeerPlace Networks, LLC, to design and develop a statewide client data system. Statewide databases are software systems created, developed, or maintained by a state agency, such as NYSOFA. The new Statewide Client Data System will launch September 15, 2016. The purpose of the Go-Dark period is to allow PeerPlace to migrate the data from the current AAA's individual systems into the new Statewide Client Data System.

Introduction

In preparation for the "Go-Dark" period between the last day that live data can be entered into current databases and the go-live date for the Statewide Client Data System on Sept. 15, NYSOFA is providing the following guidance to all AAAs and their providers:

For all programs except NY Connects:

- The final date and time for data entry into your current databases is **5pm, Friday, August 5, 2016.**
- Data entered up until **5 pm August 5, 2016 that includes at least one unit of service (units could be 0.25 or more) after April 1, 2009 will be migrated into the Statewide Client Data System.**
- The **Go-Live date** for the Statewide Client Data System is **Sept. 15, 2016**.

The Statewide Client Data System incorporates consent processes that meet Older Americans Act and other laws governing consent to capture and share client information. In order to provide you with the details you will need concerning consent requirements during the Go-Dark period, NYSOFA will provide additional guidance. **For NY Connects:**

- The final date for data entry is **July 31, 2016.**

Please share this document with the appropriate staff as soon as possible. If you have questions or need clarification, please contact your ASR.

This TAM (INSERT # when assigned) covers Go-Dark period preparation for the following reporting items:

- Client Data
- BIP Caregiver
- NYConnects
- HIICAP

Key Things to Keep In Mind

- NO DATA entered into your database after 5pm August 5, 2016 WILL BE MIGRATED FROM CURRENT DATABASES INTO THE STATEWIDE CLIENT DATA SYSTEM.
- **During the Go-Dark period (**August 6 to September 14), your system will still be up and running. You may choose to use your current system to view, enter data, and print reports. Data entered during this period must be re-entered once the system goes live.
- HIICAP – see HIICAP section for guidance on entering HIICAP data directly into SHIPTalk during August and September.
- CAARS will remain unchanged and will be available during this period.

Statewide Client Data System Go-Live on September 15

- Your agency will be responsible for entering all data you collect and/or enter into your data system during the Go-Dark period into the new Statewide Client Data System after Go-Live.

- For data collected during the **Go-Dark period (August 6 to September 14)** the target date to be manually entered into the Statewide Client Data System, is **December 31, 2016**.

Client Data Reporting

AAAs are required to collect and report Service, Basic Client Profile and Assessment data, including Care and Service Plan.

There is no change to reporting requirements for the Go-Dark period. Please see Appendix 1 for a quick summary of the minimum data that you need to collect during Go-Dark Period and report after the new system Go-Live.

Service Data and Basic Client Profile Data: Go-Dark

During the Go-Dark period, to simplify the data recording and data entry process for **SERVICE DATA**, we recommend the following:

For **EXISTING CLIENTS**, AAAs and their service providers can continue using their current system to record service data (i.e., service date, service type, funding source, and units) during the Go-Dark period, August 6th-September 14th.

Note: The existing client profile records in your current system through 5 pm on August 5, 2016 will be migrated to the new Statewide Client Data System. Consent has been assumed to be on record for all existing clients. By utilizing existing records, you will only need to record the service data. Keep in mind, that any new service data entered into your existing system after August 5th WILL NOT be migrated over to the new Statewide Client Data System. Thus, please print out and/or save electronic copies of service data related reports and re-enter to the new system.

Note: if you choose not to enter service data to your current system, you need to develop/use a tool to record the service data for future entry into the new Statewide Client Data System. A simple Excel worksheet may work for this purpose (see sample Service Record form/ worksheet).

For **NEW CLIENTS**: The AAAs and their providers have two options from which to choose:

Option 1. After obtaining written consent*, establish a Client Record in the existing data collection system, enter Service Data to the existing data collection system, then re-enter the data to the new statewide data system after "Go-Live".

Basic information is needed for creating the client record.

- Sample registration/intake form to record the minimum client profile information is attached so you know how to establish a client record so it can be re-entered into the new statewide data system after "Go-Live."
- Written consent is required and copies should be maintained so they can be rescanned and attached to client record in new Statewide Client Data System.
- Once the client record is established, service data can be entered into the existing system. Keep in mind, that any new client records or service data entered into your existing system after August 5th WILL NOT be migrated over to the new Statewide Client Data System and will need to be entered into the new system after September 15, 2016.

Option 2. Keep everything on paper, enter data and scan written consent* documents into new system after September 15.

- NYSOFA has provided a sample worksheet to record the required service data (see attached Service Record form)
- NYSOFA has provided sample registration/intake form to record the minimum client profile information (see attached Simple Sample Intake Form)
- Utilize local Release of Information and/or HIPAA Release forms to obtain written consent.

** Consent requirements will be provided in a separate document.*

Care Plans and Assessments: Go-Dark

Assessment Data: Only applies to clients receiving Cluster 1 services. Cluster 1 services are: Personal Care level I and II, CD In-home services, Home Health Aide, Home Delivered Meals, Adult Day Services, and Case Management. There are three options from which to choose:

Option 1. You can save completed assessments and care plans into a Word document on your hard drive so that they remain available and can be edited as you conduct re-assessments. ***Note**:* The information from these paper copies will need to be entered into the new Statewide Client Data System after Go-Live. **WRITTEN CONSENT* MUST BE OBTAINED FOR All NEW CLIENTS.**

OR

Option 2. Use blank paper copy COMPASS assessment forms (see attached). ***Note**:*

The information from these paper copies will need to be entered into the new Statewide Data System after Go-Live. **WRITTEN CONSENT* MUST BE OBTAINED FOR ALL NEW CLIENTS.**

OR

Option 3. You may continue to enter data into existing client data system and print off updated and/or completed assessments and care plans (as soon as possible) so you can utilize to re-enter/update in the new Statewide Client Data System. Keep in mind, that any new/updated assessment and care plan data entered into your existing system after 5 pm on August 5, 2016 WILL NOT be migrated over to the Statewide Client Data System. **WRITTEN CONSENT* MUST BE OBTAINED FOR ALL NEW CLIENTS.**

* *Consent requirements will be provided in a separate document.*

EISEP Cost Share: Go Dark

There are two options from which to choose:

Option 1. Use blank paper copy of EISEP Cost Share form (attached). This information can then be utilized to enter into the new Statewide Client Data System.

OR

Option 2. Continue to utilize the electronic EISEP Cost Share form. Keep in mind, that any new/updated EISEP Cost Share data entered into your existing system after 5 pm on August 5, 2016 WILL NOT be migrated over to the new Statewide Client Data System.

KEY THINGS TO KEEP IN MIND

- **ANY DATA ENTERED INTO YOUR EXISTING SYSTEM AFTER 8/5/2016 WILL NOT BE MIGRATED BEFORE OR AFTER GO-LIVE.**

BIP Caregiver Support Program: Go-Dark

This is a new program and does not apply for all AAAs. For AAAs participating in the BIP Caregiver Support Program, you will need to continue to collect required program data.

AAAs are required to use the (attached) BIP Caregiver/Care Receiver Required Information Form (revised), issued in 15-PO-03, to capture and record caregiver and care recipient data for this program, including during the Go-Dark period.

Please refer to **15 PI-03** for specific required program data collection and reporting.

WRITTEN CONSENT* MUST BE OBTAINED FOR ALL NEW CLIENTS.

** Consent requirements will be provided in a separate document.*

NY CONNECTS: Go-Dark (Please note earlier date of July 31, 2016)

There are two options from which to choose:

Option 1. Use blank paper copy NY Connects Intake forms. ***Note***: The information from these paper copies will need to be entered into the new Statewide Client Data System after Go-Live. **WRITTEN CONSENT* MUST BE OBTAINED FOR ALL NEW CLIENTS.**

OR

Option 2. You may continue to enter data into your existing data system and print completed NY Connects intakes **as soon as possible** so you can utilize to re-enter/update in the new Statewide Data System. **WRITTEN CONSENT* MUST BE OBTAINED FOR ALL NEW CLIENTS.**

** Consent requirements will be provided in a separate document.*

KEY THINGS TO KEEP IN MIND

- **ANY DATA ENTERED INTO YOUR EXISTING SYSTEM AFTER July 31, 2016 WILL NOT BE MIGRATED BEFORE OR AFTER GO-LIVE.**
- In order to ensure that we receive as much data as possible for the final migration we are asking for you to submit the *NY Connects 3rd Quarter delimited file* with the original start date of October 2011 (some counties may differ depending on when they started submitting the delimited files) and use the end date of July 31st. If you have already submitted the NYConnects.txt file for the 3rd Quarter report we will need you to resubmit using the July 31st end date.
- **NYSOFA must receive the NYConnects.txt file by August 1, 2016 for the final data migration.**

HIICAP: Go-Dark

For those counties that utilize a HIICAP module in their current data collection system which then gets uploaded into SHIPTalk:

- HIICAP programs will need to **input all data directly into SHIPTalk** to ensure your data is able to be transmitted to ACL. All data must include Client Contacts (CC) as well as Public and Media Events (PAM).

NOTE:
- ✓ **HIICAP data (CC and PAM) should be entered into SHIPTalk August and September 2016.**
- ✓ **You should begin to utilize the PeerPlace system to enter your data effective October 1, 2016**.

HIICAP Counselor names and SHIP- National Performance Reporting (NPR) IDs

HIICAP Counselor names and SHIP NPR IDs WILL NOT be migrated into the new statewide data system. You should:

- Print out a report that lists all of your HIICAP Counselors, and any pertinent data including SHIP NPR IDs that currently appear in your existing PeerPlace, Harmony or Home-grown system. This will assist you in adding the HIICAP Counselors into the new Statewide Database.

CAARS Quarterly Reporting

Throughout the transition to the Statewide Client Data System -- including the Go-Dark period, **NYSOFA Reporting site** https://reporting.aging.ny.gov **will remain unchanged and will be available.** This includes the quarterly CAARS Report, NY Connects, and Meal Site list/roster, as well as other program specific reports.

Preparing for System Go-Live

Reports

AAAs and their service providers will want to export any reports that have been updated in your current system, and save them on hard drive/network or print out all available reports, such as:

- rosters, route sheets, etc. down to the site level if available
- service utilization records for the clients receiving services during the “Go-Dark period”

- program/client profile summary reports, which will provide totals to be used during your review
- program specific reports, such as those related to the Title III-E caregiver program; missing data reports
- Referral Reports
- Cost Share Reports (for SAMS users)
- Consumer Group related reports (for SAMS users)*
- Any customization reports or other reports utilized

These reports will assist you in developing event profiles (rosters), route sheets, and re-entering required data into the new Statewide Client Data System. Please make certain you have them printed and available.

**More guidance will be provided.*

Attachments

Attachments WILL NOT be migrated over to the new system. Any attachments needed (e.g., applications, documents, Release of Information forms, etc.) must be printed so you can scan them into the new Statewide Client Data System and attach to a specific client record.

Entering Data After Go-Live

All required data collected from the Go-Dark period needs to be entered manually into the Statewide Client Data System by the AAAs and/or the service providers. This should take place as soon as possible. **The target date for completing data entry for the data collected during the Go-Dark period into the Statewide Client Data System is December 31, 2016.**

Note: For Harmony users, please make certain of the termination date for your current system. Please have all the needed reports, documents, and/or attachments before your current system terminates. More guidance will be provided regarding termination of your current systems.

Attachments

- Sample Service Record Form to record required service data.
- **Sample registration/intake forms to record the minimum client profile information:**
  - Sample Congregate Service Intake/Registration Form 2016
  - Sample III-E Registration Form 2016
  - Sample Simple Intake Form 2016
- COMPASS assessment form from 14-PI-02 (Attachment E)
- Peer Place COMPASS Blank Form
- 16-PI-10 **which includes** EISEP Cost Share form
- NY Connects Intake forms
- BIP Caregiver/Care Receiver Required Information Form (revised)

Appendix 1

Service Data: we need to have service date, service type, service units, and funding source data reported.

Basic **Client Profile**: the minimum requirement differs depending on the client type.
Y= indicates collection and reporting of that information.

Data	Clients Receiving Registered Services*	Caregivers Receiving IIIE Group 1 Services
Date of Birth (Age)	Y	Y
Sex	Y	Y
Rural	Y	Y
Ethnicity (Hispanic / Non-Hispanic)	Y	Y
Race	Y	Y
Poverty Status	Y	
Living Arrangement	Y	
Nutrition Risk Status**	Y	
Limited English Proficiency	Y	
Relationship to Care Receiver		Y

What are Registered Services? (Cluster 1 & Cluster 2)

Personal Care level I and II, CD In home services, Home Health Aide, Home Delivered Meals, Adult Day Services, Case Management, Congregate Meals, Nutrition Counseling, and Assisted Transportation. ** For clients Assisted Transportation, nutrition risk data is optional.

What about Cluster 1 clients?

Clients receiving cluster 1 services are required to receive assessment (COMPASS) and Care Plan to meet NYSOFA Minimum Data Set requirements (see 14-PI-02).

What about Cluster 3 clients?

Cluster 3 clients including caregivers receiving IIIE funded Group 2 Services, no minimum data is required for individual clients. Service data (service units) is still

required. You also need to have a system to help you to estimate people count for each of the cluster 3 & IIIE group 2 services.

Below is quick summary to show the service clusters/groups:

Service Grouping	Service Type
Registered Services: Cluster 1	Personal Care level I and II, CD In home services, Home Health Aide, Home Delivered Meals, Adult Day Services, Case Management
Registered Services: Cluster 2	Congregate Meals, Nutrition Counseling, and Assisted Transportation
Cluster 3 Services	Transportation, Legal Services, Nutrition Education, Information and Assistance, Outreach, In-Home Contact& Support, Sr. Center Recreation/Education, Health Promotion, PERS, Caregiver Services, and Other
IIIE Group 1 Services	Counseling/Support Groups/Training, Supplemental Services, Respite Care
IIIE Group 2 Services	Access Assistance, Information Services

PROGRAMS AFFECTED:

☒ Title III-B ☒ Title III-C-1 ☒ Title III-C-2

☒ Title III-D ☒ Title III-E ☒ CSE ☒ WIN ☒ Energy

☒ EISEP ☒ NSIP ☒ Title V ☒ HIICAP ☐ LTCOP

☐ Other:

CONTACT PERSON: **TELEPHONE:**

Sample Service Records Form

Service Provider:

First Name	Last Name	Service Date	Service Type	Unit of Service	Funding Source

Congregate Services 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 this form should only be completed with staff assistance.

PROVIDER ID: ☐☐-☐☐☐☐☐☐☐ **Intake Date:** ☐☐/☐☐/☐☐☐☐

CLIENT INFORMATION: Gender: O Male O Female DOB: ☐☐-☐☐-☐☐☐☐ Veteran: O Yes O No

Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐ First Name: ☐☐☐☐☐☐☐☐☐☐☐☐ Mid Init ☐

Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ St: ☐☐ Zip + 4: ☐☐☐☐☐-☐☐☐☐ Co: ☐☐

Phone: (☐☐☐)☐☐☐-☐☐☐☐ Living Status: ☐ 1=Alone, 2=With Spouse Only, 3=With relatives, 4=With non-relatives, 5=With Spouse and others, 6=Others

Marital Status: O Married O Widowed O Divorced O Never Married O Domestic Partner or Significant Other O Separated

Number in Household: ☐☐

Ethnicity: O Hispanic O Non-Hispanic

Race: O White O Black O American Indian/Alaskan Native O Asian O Native Hawaiian/Pacific Islander O Other Race O 2 or More Races O White (Alone) Hispanic

Income Status: (Below Poverty Level) **100%** O Yes O No **150%** O Yes O No

Frail\Disabled: O Yes O No

Emergency Contact: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Phone: (☐☐☐)☐☐☐-☐☐☐☐

SERVICES INFORMATION:

Limited English Proficiency: ☐ Primary Language: _____

Cluster II Services

- ☐ Congregate Meals
- ☐ Nutrition Counseling
- ☐ Assisted Trans.

Cluster III Services

- ☐ Info & Referral
- ☐ Legal Services
- ☐ Transportation
- ☐ Nutrition Education
- ☐ Outreach
- ☐ 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.

Determine Income Status **(Staff Use Only)**

- **Poverty Status is determined by household size and household income**

If Annual Household Income is not answered, please use the following table to determine the income status –

For example, for two people household, ask- is your household income less than $16,020 a year, if answer is yes, both 100% and 150% check Yes; If answer is no, ask - is your household income less than $ 24,030 a year– If answer is yes, 100% check No, 150% check Yes

Income Status: (Below Poverty Level) **100%** ○Yes ○ No **150%** ○Yes ○No

Household size	**2016 Poverty Income Guidelines Annual Household Income**	
	100%	150%
1	$11,880	$17,820
2	**$16,020**	**$24,030**
3	$20,160	$30,240
4	$24,330	$36,450

For each additional family member at 100%, add: $4,160

For each additional family member at 150%, add: $6,210

Sample Simple Intake Form

Name Service

Dear Participant: By providing the information requested below, you will help us to demonstrate the effectiveness of the services we provide and enable us to obtain future funding to continue to provide you with services and support. This information is strictly confidential.

Last Name:	First Name:	Mid Init
Address:		County
City:	St:	Zip + 4:
Phone: ( ) -	Gender: O Male O Female	Ethnicity O Hispanic or Latino O Not Hispanic or Latino
DOB: - -		

Race:

- O American Indian/ Alaskan Native
- O Asian
- O Black
- O White
- O Native Hawaiian/Pacific Islander
- O Other Race
- O 2 or More Races

Living Arrangement: O1=Alone, O 2=With Spouse only, O3=With relatives, O4=With non-relatives, O5=With Spouse and others, O 6=Others

Number of People in Household: _____

Annual Household Income: _____

<u>Determine Income Status</u> (Staff Use Only)

- **Poverty Status is determined by household size and household income**

If Annual Household Income is not answered, please use the following table to determine the income status –

For example, for two people household, ask- is your household income less than $16,020 a year, if answer is yes, <u>both 100% and 150% check Yes</u>; If answer is no, ask - is your household income less than $ 24,030 a year– If answer is yes, <u>100% check No, 150% check Yes</u>

Income Status: (Below Poverty Level) **100%** ○Yes ○ No **150%** ○Yes ○No

Household size	**2016 Poverty Income Guidelines Annual Household Income**	
	100%	150%
1	$11,880	$17,820
2	**$16,020**	**$24,030**
3	$20,160	$30,240
4	$24,330	$36,450

For each additional family member at 100%, add: $4,160

For each additional family member at 150%, add: $6,210

Sample Title III-E
Registration Form

Dear Participant: By providing the information requested below, you will help us to demonstrate the effectiveness of the services we provide to caregivers and enable us to obtain future funding to continue to provide you with services and support. This information is strictly confidential.

Last Name:	First Name:	Mid Init
Address:		County
City:	St:	Zip + 4:
Phone: ( ) -	Gender: Male Female	Ethnicity: Hispanic or Latino; Not Hispanic or Latino
DOB: - -	Limited English Proficiency:	

Race:

- American Indian/ Alaskan Native
- Asian
- Black
- White Hispanic
- White not Hispanic
- Native Hawaiian/Pacific Islander
- Other Race
- 2 or More Races

What is your relationship to the person(s) you provide care to (check all that apply):	
If caring for an older person age 60 or older, or a person of any age with Alzheimer's disease or other dementia: _____ Husband _____ Wife _____ Daughter/Daughter-in-law _____ Son/Son-in-law _____ Other Relative _____ Non-Relative	If a grandparent or other relative at least 55 years old and not the parent, caring for a child no older than 18, or a child of any age with a disability: _____ Grandparent _____ Other Relative _____ Non-Relative

Name of care receiver:		
Last Name:	First Name:	Mid Init

If you have more than one care receiver, please provide their name(s) and your relationship to them.

Care Receiver(s)		Relationship
#2		
#3		
#4		

Would you like us to keep you informed of other caregiver support services provided by *Provide your office's name here.*

the Area Agency on Aging? ○ Yes ○ No

THANK YOU FOR PROVIDING THIS INFORMATION

Contact the <u>insert county name and contact information</u> if you have questions or want to find out about other services for elders and their caregivers.

NYSOFA246 (04/14)

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

INTAKE INFORMATION

A. Person's Name:

B. Address:

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

D. Date of Referral:

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

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

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

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

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

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

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: _____

I 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	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Reads	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Understands orally	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

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

P. Living-Arrangement:

[ ] Alone [ ] With Spouse Only [ ] With Spouse & others

[ ] With Relatives (excludes spouse) [ ] With Non-Relative(s), Domestic Partner

[ ] Others Not listed

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

[ ] Physical Abuse [ ] Active and Passive Neglect

[ ] Sexual Abuse [ ] Self Neglect

[ ] Emotional Abuse [ ] Domestic Violence

[ ] Financial Exploitation [ ] Other (e.g. Abandonment)

Was this referred to:

[ ] Adult Protective Services [ ] AAA

[ ] Police Agency [ ] Other _____

[ ] Domestic Violence Service Provider [ ] Not Referred

R. Emergency Contact: _____

Primary	**Secondary**
Name:	Name:
Address:	Address:
Relationship:	Relationship:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:

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

II HOUSING STATUS

A. Type of Housing:
[ ] multi-unit housing [ ] single family home [ ] other

B. Person (check): [ ] owns [ ] rents [ ] other Specify

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

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

Comments:

III HEALTH STATUS

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

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

C. Does the person have a self-declared chronic illness and/or disability? (Check all that apply)

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

*May indicate need for assessment by nutritionist

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

[ ] Accessible vehicle	[ ] Hearing Aid
[ ] Bed rail	[ ] Lift chair
[ ] Cane	[ ] Scooter
[ ] Denture: [ ] Full [ ] Partial	[ ] Walker
[ ] Glasses	[ ] 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?
[ ] Yes (If yes, describe the reason for the most recent ER visit) Month: Year: [ ] No

I. Has a PRI and/or DMS-1 been completed in the past 6 months?
[ ] Yes (If Yes, describe the reason for, completion) [ ] No

____DMS-1 Score:

Completed by _____
(Name and Affiliation)
Date completed: Month: _____ Year: _____

____PRI Score:

Completed by: _____
(Name and Affiliation)
Date completed: Month: _____ Year: _____

Comments:

J. Alcohol Screening Test - The CAGE Questionnaire
Check all that apply
Have you ever felt you should cut down on your drinking? [ ]

Have people annoyed you by criticizing your drinking? [ ]

Have you ever felt bad or guilty about your drinking? [ ]

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

IV. NUTRITION

A. Person's height _____ Source: _____

B. Person's weight _____ Source: _____

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

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

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

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

[ ] Yes (If yes, check all that apply)

[ ] Texture-Modified [ ] Calorie Controlled Diet [ ] Sodium Restricted

[ ] Fat Restricted [ ] High Calorie [ ] Renal

[ ] Other {Specify}_____

[ ] No (If No, Check all that apply)

[ ] Regular [ ] Special Diet (Check all//that apply)

[ ] Ethnic/Religious (specify) _____ [ ] Vegetarian

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

H. Does the person use nutritional supplements?

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

I. Nutritional Risk Status

Check all that apply and circle the corresponding number at right

		Score
[ ]	Has an illness or conditions that made me change the kind and/or amount of food 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
[ ] cooperative
[ ] dementia
[ ] depressed
[ ] disruptive socially
[ ] hallucinations
[ ] hoarding
[ ] impaired decision making
[ ] lonely
[ ] memory deficit
[ ] physical aggression
[ ] sleeping problems
[ ] suicidal thoughts
[ ] verbal disruption
[ ] self-neglect
[ ] suicidal behavior
[ ] worried or anxious
[ ] other (specify)

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

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

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

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

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

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

Comments:

VI. PRESCRIBED

A. MEDICATIONS.

Name	Dose/Frequency	Reason Taken

B. Primary Pharmacy Name Phone

C. Does the person have any problems taking medications?

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

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

F. Obtaining medications [ ] Yes, if Yes. Describe [ ] No

G. Other (Describe)

Comments :

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

Activity Status: *(Use for Sec. VII & VIII)*

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.

Check if assistance is/will be provided by

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

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

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

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

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

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

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

IX. SERVICES CLIENT CURRENTLY IS RECEIVING

A. What formal service(s) does the person currently receive? *(Check all that apply)*
[ ] none utilized

Provider Information

[ ] adult day health care

[ ] assisted transportation
[ ] caregiver support

[ ] case management
[ ] community-based food program

[ ] consumer directed in-home services
[ ] congregate meals
[ ] equipment/supplies
[ ] friendly visitor/telephone reassurance

[ ] health promotion
[ ] health Insurance counseling
[ ] home health aide
[ ] home delivered meals
[ ] hospice
[ ] housing assistance
[ ] legal services
[ ] mental health services
[ ] nutrition counseling
[ ] occupational therapy
[ ] outreach

[ ] personal care level 1

[ ] personal care level 2
[ ] personal emergency response system (PERS)

[ ] physical therapy
[ ] protective services
[ ] respite
[ ] respiratory therapy
[ ] senior center
[ ] senior companions
[ ] services for the blind
[ ] shopping

[ ] skilled nursing
[ ] social adult day care
[ ] speech therapy
[ ] transportation
[ ] other (specify)_____

X. INFORMAL SUPPORT STATUS

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

Primary Informal Support

1. Name:

Address:

Relationship:

Home Phone: Work Phone: Cell Phone:

E-mail:

Involvement: (Type of help/frequency)

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

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

1. c. Are there any factors that might limit this informal support's involvement? (Check all that apply)
[ ] job [ ] finances [ ] family [ ] responsibilities [ ] physical burden [ ] transportation
[ ] emotional burden [ ] health problems [ ] reliability [ ] living distance

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

1. e. Does the caregiver identify the need for respite? [ ] Yes [ ] No
If yes, when? [ ] Morning [ ] Afternoon
[ ] Evening [ ] Overnight
[ ] Weekend [ ] Other

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

[ ] Adult Day Services [ ] Personal Care Level 1 [ ] Personal Care Level 2

[ ] In Home Contact & Support (Paid Supervision)

1.g. Would the caregiver like to receive information about other caregiver services?
[ ] Yes [ ] No

Secondary Informal Support:

2. Name:

Address:

Relationship:

Home Phone: Work Phone: Cell Phone:

E-mail:

Involvement: (Type of help/frequency)

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

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

[ ] willing to accept help [ ] unwilling to accept any help

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

[ ] job [ ] finances [ ] family [ ] responsibilities [ ] physical burden [ ] transportation

[ ] emotional burden [ ] health problems [ ] reliability [ ] living distance

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

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

If yes, when? [ ] Morning [ ] Afternoon
[ ] Evening [ ] Overnight
[ ] Weekend [ ] Other

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

[ ] Adult Day Services [ ] Personal Care Level 1 [ ] Personal Care Level 2

[ ] In Home Contact & Support (Paid Supervision)

2.g. Would the caregiver like to receive information about other caregiver services?
[ ] Yes [ ] No

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

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

Comments:

XI. MONTHLY INCOME

A.

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

B. Number of people in household _____

C. Is client a veteran? _____

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

XII. BENEFITS/ENTITLEMENTS

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

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

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

XIII. CARE PLAN

Person's Name: _____ Date: _____

Address: _____ Prepared by: _____

_____ Person's Phone: _____

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

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

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

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

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

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

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

Service Provider Date Placed on List

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

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

Signature and Title

SERVICE/CARE PLAN TERMINATION

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

B. Termination Date:

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

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

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

E. Terminated by: _____

_____ _____
Signature Title

_____ _____ _____ _____
Date: Work Phone: Cell Phone: E-mail

Case Identification

Assessment/Reassessment Date *:

Assessor`s Name:

Agency/Program Name:

Reason for Assessment/ Reassessment: ( ) Event Based ( ) Initial ( ) Routine

Source of Information:

Comments:

Next Assessment Date (mm/dd/ yyyy) *:

Client Information

Last Name: First Name:

Middle Name:

Address 1: Address 2:

City: State:

Zip: County:

Email Address: Phone (Home) (###-###-####):

Social Security No.:

Marital Status: ( ) Divorced ( ) Domestic Partner or Signif Other ( ) Married ( ) Never Married ( ) Separated ( ) Single ( ) Widowed

Sex: ( ) Female ( ) Male ( ) Unspecified

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?

Transgender - Gender Identity or Expression: ( ) No ( ) Yes, transgender male to female ( ) Yes, transgender female to male ( ) Yes, transgender, do not identify as male or female ( ) Did not answer

Birth Date (mm/dd/yyyy):

Name:

Race:

( ) 2 or More Races
( ) Amer Ind / Alaskan Native
( ) Asian
( ) Black or African American
( ) Native Hawaiian / Other Pacific Islander
( ) Not Available
( ) Other Race
( ) Refused to Answer
( ) White Hispanic
( ) White not Hispanic

Ethnicity:

( ) Hispanic / Latino
( ) Missing / Unknown
( ) Not Hispanic / Latino
( ) Refused to Answer

Sexual Orientation:

( ) Heterosexual or Straight
( ) Homosexual or Gay
( ) Lesbian
( ) Bisexual
( ) Not Sure
( ) Did Not Answer
( ) Other

Creed:

( ) Christianity
( ) Islam
( ) Hinduism
( ) Buddhism
( ) Judaism
( ) Did Not Answer
( ) Other

National Origin:

Primary Language (Check all that apply)

English:

[ ] Speaks
[ ] Reads
[ ] Understands orally

Spanish:

[ ] Speaks
[ ] Reads
[ ] Understands orally

Chinese:

[ ] Speaks
[ ] Reads
[ ] Understands orally

Russian:

[ ] Speaks
[ ] Reads
[ ] Understands orally

Italian:

[ ] Speaks
[ ] Reads
[ ] Understands orally

French/Haitian Creole:

[ ] Speaks
[ ] Reads
[ ] Understands orally

Korean:

[ ] Speaks
[ ] Reads
[ ] Understands orally

Other:

[ ] Speaks
[ ] Reads
[ ] Understands orally

Name:

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

Living-Arrangement:
[ ] Alone
[ ] Non-Relatives, Domestic Partner
[ ] Not Available
[ ] Others
[ ] Relatives
[ ] Spouse & Others
[ ] Spouse Only

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)
[ ] None Reported

Was this referred to:
[ ] Adult Protective Services
[ ] AAA
[ ] Police Agency
[ ] Other
[ ] Domestic Violence Service Provider
[ ] Not Referred

Other specify:

Emergency Contacts

Primary

Name:

Address:

Relation:

Phone (Home) (###-###-####):

Phone (Cell) (###-###-####):

Secondary

Name:

Address:

Relation:

Phone (Home) (###-###-####):

Phone (Cell) (###-###-####):

Client Information

Is the client frail?: ( ) No ( ) Yes

Is the client disabled?: ( ) No ( ) Yes

Housing Status

Type of Housing:
( ) Apartment
( ) Condominium
( ) Multi-Unit
( ) Other
( ) Single Family

Housing Status:
( ) Other
( ) Own
( ) Rent

Is Neighborhood Safety an Issue: ( ) No ( ) Yes

Landlord Name:

Housing Comments:

Home Safety Checklist

Accumulated garbage?:	[ ]	Dirty living areas?:	[ ]
Bedroom-bath traffic lane has obstacles?:	[ ]	Cluttered stairs/walkways?:	[ ]
Cords/wires across walkways?:	[ ]	Doorway widths are inadequate?:	[ ]
Exposed wiring/electric cords?:	[ ]	Inadequate heating/cooling?:	[ ]
Inadequate hot/cold water?:	[ ]	Inadequate lighting in living areas?:	[ ]
Insects/vermin?:	[ ]	Loose scatter rugs in one or more rooms?:	[ ]
No access to phone/emergency numbers?:	[ ]	No grab bar at toilet/bathtub?:	[ ]
No handrails on stairways?:	[ ]	No light or switch in reach of bed?:	[ ]
No locks on doors/windows?:	[ ]	No rubber mat/decals in bath tub/ shower?:	[ ]
No telephone near bed?:	[ ]	Bad odors?:	[ ]
Carbon Monoxide detectors not present/not working?:	[ ]	Smoke detectors not present/not working?:	[ ]
Plumbing problem?:	[ ]	No lighting in bathroom or hallway?:	[ ]
Stairs are not well lit?:	[ ]	Stairs are in poor condition?:	[ ]
None Apply/Satisfactory:	[ ]	Referral needed for In-home Safety Assessment:	[ ]

Housing Safety Comments:

Health Status

Has Medicaid: ( ) No ( ) Yes

Medicaid No.:

Medicaid Pending: ( ) No ( ) Yes

Date Applied (mm/dd/yyyy):

Has Medicare: ( ) No ( ) Yes

Medicare No.:

Name:

Medicare Type:

( ) A and B
( ) A and D
( ) A only
( ) A, B and D
( ) A, B, and C
( ) A, B, C, and D
( ) B and D
( ) B only
( ) D only

Prescription Coverage Plan:

Health Ins Provider:

Health Ins. No.:

Secondary Health Ins. Provider:

Secondary Health Insurance No:

Other Health Ins. Provider:

Other Health Insurance No:

Physician:

Hospital:

Primary Pharmacy Name:

Primary Pharmacy Phone:

Clinic/HMO:

Medical History/Health History

Chronic Illness/Disability:

[ ] Acid Reflux
[ ] Alcoholism
[ ] Allergies
[ ] Alzheimer`s
[ ] Anemia
[ ] Anorexia
[ ] Arthritis
[ ] Asthma
[ ] Back Problems
[ ] Cancer*
[ ] Cellulitis
[ ] Chronic Constipation
[ ] Chronic Diarrhea
[ ] Chronic Obstructive Pulmonary Disease (COPD)
[ ] Chronic Pain
[ ] Colitis
[ ] Colostomy
[ ] Congestive Heart Failure
[ ] Decubitus Ulcers
[ ] Dehydration
[ ] Dementia
[ ] Dental Problems*
[ ] Developmental Disabilities
[ ] Diabetes*
[ ] Dialysis
[ ] Diarrhea
[ ] Digestive Problems*
[ ] Diverticulitis
[ ] Emphysema
[ ] Fractures (Recent)
[ ] Frequent Falls
[ ] Gall Bladder Disease
[ ] Glaucoma
[ ] Hearing Impairment
[ ] Heart Disease*
[ ] Hiatal Hernia
[ ] High Blood Pressure*
[ ] High Cholesterol
[ ] Hyperglycemia
[ ] Hypoglycemia
[ ] Incontinence
[ ] Legally Blind
[ ] Liver Disease
[ ] Low Blood Pressure
[ ] Multiple Sclerosis
[ ] Muscular Degeneration
[ ] Osteoporosis
[ ] Other
[ ] Oxygen Dependent
[ ] Paralysis
[ ] Parkinson`s
[ ] Pernicious Anemia
[ ] Renal Disease
[ ] Respiratory Problems
[ ] Shingles
[ ] Smelling impairment*
[ ] Speech Problems
[ ] Stroke
[ ] Swallowing difficulties
[ ] Taste impairment*
[ ] Thyroid
[ ] Traumatic Brain Injury
[ ] Tremors
[ ] Tuberculosis
[ ] Ulcer
[ ] Urinary Tract Infection
[ ] Visual Impairment

Name:

Possible Action:

Insulin Dependent: ( ) No ( ) Yes

Other Diagnosis/Allergies:

Date of last visit to Primary Medical Provider:

Visit Doctor less than once a year: ( ) No ( ) Yes

Require Comprehensive Medical Exam: ( ) No ( ) Yes

Problems with Medication:

[ ] Adverse reactions
[ ] Allergies
[ ] Cost of medication
[ ] None
[ ] Obtaining medications
[ ] Other
[ ] Sensitivities

If yes to problems with medication, describe:

Medical Information Comments:

Assistive Devices

Devices Used:

[ ] Accessible vehicle
[ ] Bed rail
[ ] Braces
[ ] Cane
[ ] Commode
[ ] Denture - Full
[ ] Denture - Partial
[ ] Eyeglasses
[ ] Grab Bars
[ ] Hand Held Shower
[ ] Hearing Aid
[ ] Other
[ ] PERS
[ ] Prosthesis
[ ] Raised Toilet Seat
[ ] Scooter
[ ] Transfer Bench
[ ] Tub Seat
[ ] Walker
[ ] Wheelchair / Transportable folding

Devices Needs:

[ ] Accessible vehicle
[ ] Bed rail
[ ] Braces
[ ] Cane
[ ] Commode
[ ] Denture - Full
[ ] Denture - Partial
[ ] Eyeglasses
[ ] Grab Bars
[ ] Hand Held Shower
[ ] Hearing Aid
[ ] Other
[ ] PERS
[ ] Prosthesis
[ ] Raised Toilet Seat
[ ] Scooter

Name:

[ ] Transfer Bench [ ] Tub Seat [ ] Walker [ ] Wheelchair / Transportable folding

Client/Caregiver needs training to use devices: ( ) No ( ) Yes

If Yes, Explain:

Oxygen Dependent: ( ) No ( ) Yes

Dialysis: ( ) No ( ) Yes

Assistive Devices Comments:

Health Care Events

Date(mm/dd/yyyy) *:

Author:

Health Care Event*: ( ) Alcohol Screening Test ( ) Clinic Visit ( ) DMS-1 ( ) Emergency Room ( ) Hospital Visit ( ) Other ( ) Physician Visit ( ) PRI

Event Date (MM/DD/YYYY)*:

Health Care Events Comments:

The CAGE Questionnaire (Check all that apply)

Alcohol Screening Test

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)?: [ ]

DMS-1

DMS-1 Score:

Completed by (Name and Affiliation):

PRI

PRI Score:

Completed by (Name and Affiliation):

Legal Information

Power of Attorney: ( ) No ( ) Yes

Power of Attorney Name:

Power of Attorney Type: ( ) Durable ( ) Finance ( ) Springing

Do Not Resuscitate (DNR) Request: ( ) No ( ) Yes

Health Care Proxy:

Living Will: ( ) No ( ) Yes

Estate Will: ( ) No ( ) Yes

Legal Comments:

Nutrition

Height - Feet:

Height - Inches:

Weight (LBS):

Body Mass Index(BMI):

Possible Action:

Nutrition Problems:

[ ] Anorexic Behaviors
[ ] Bulimic Behaviors
[ ] Compulsive Overeating
[ ] Decreased Appetite
[ ] Dehydration
[ ] Dental Problems
[ ] Difficulty Chewing
[ ] Difficulty Swallowing
[ ] Digestive Problems
[ ] Overweight
[ ] Taste Impairment
[ ] Underweight

Nutritional Challenges:

[ ] Has a Physician Diagnosed Food Allergy
[ ] Has a Physician Prescribed Modified / Therapeutic Diet
[ ] Inadequate Cooking Facilities
[ ] Inadequate Freezer
[ ] Inadequate Refrigerator
[ ] Requires Nutritional Supplements
[ ] Unable to Cut up Food
[ ] Unable to Open Containers / Cartons

Name:

If Yes to Nutritional Challenges, describe.:

If Yes to Physician Prescribed Modified Diet,indicate diet type.:

[ ] Calorie Controlled [ ] Diabetic [ ] Fat Restricted [ ] High Calorie
[ ] Other [ ] Renal [ ] Sodium Restricted [ ] Texture Modified

Does the person follow this modified diet?: ( ) No ( ) Yes

If No to Physician Prescribed Modified Diet,indicate diet type.: [ ] Diabetic [ ] Ethnic / Religious [ ] Regular [ ] Vegetarian

Weight changes in past 6 months: ( ) N/A ( ) No ( ) Yes

If Yes, How Many Pounds (+ Gained/ - Lost): Possible Action:

Number of meals taken daily:

Does client ever go without food: ( ) No ( ) Yes

If Yes, Explain:

Does client have adequate food in home: ( ) No ( ) Yes

Nutrition Comments:

NSI

I have an illness or condition that made me change the kind and/or amount of food I eat: ( ) No ( ) Yes

I eat fewer than 2 meals per day: ( ) No ( ) Yes

I eat few fruits for vegetables, or milk products: ( ) No ( ) Yes

I have 3 or more drinks of beer, liquor or wine almost every day: ( ) No ( ) Yes

I have tooth or mouth problems that make it hard for me to eat: ( ) No ( ) Yes

Name:

I don't always have enough money to buy the food I need:	( ) No	( ) Yes
I eat alone most of the time:	( ) No	( ) Yes
I take 3 or more different prescribed or over-the-counter drugs a day:	( ) No	( ) Yes
Without wanting to, I have lost or gained 10 pounds in the last 6 months:	( ) No	( ) Yes
I am not always physically able to shop, cook and/or feed myself:	( ) No	( ) Yes

Total NSI Score:

Conclusion:

Comments:

Psycho-Social Status

Cognitive/Emotional Status:

[ ] Acceptance of Help	[ ] Agitation	[ ] Alert	[ ] Anxiety
[ ] Assertive - Articulates Needs	[ ] Cares for Others / Things (pets / neighbors)	[ ] Confusion	[ ] Cooperative
[ ] Critical Life Change	[ ] Dementia	[ ] Depression	[ ] Diagnosed MH Disorder
[ ] Disruptive Socially	[ ] Friends / Likeable	[ ] Hallucination	[ ] Healthy Familial Attachments
[ ] History of Mental Health Treatment	[ ] Hoarding	[ ] Impaired Decision Making	[ ] Lonely
[ ] Member of Community Organizations	[ ] Memory Deficit	[ ] Oriented	[ ] Other
[ ] Physical Aggression	[ ] Problem Behavior Reported	[ ] Recent Losses	[ ] Self-neglect
[ ] Sense of Humor	[ ] Shows Initiative	[ ] Sleeping Problems	[ ] Substance Abuse
[ ] Suicidal Behavior	[ ] Suicidal Thoughts	[ ] Verbal Disruption	

What are the client identified strengths:

Substance Abuse: ( ) No ( ) Yes

Name:

If Yes, Explain:

Problem Behavior Reported: ( ) No ( ) Yes

If Yes, Explain:

Diagnosed Mental Health Problem: ( ) No ( ) Yes

If Yes, Explain:

History of Mental Health Treatment: ( ) No ( ) Yes

If Yes, Explain:

Mental Health Evaluation Needed: ( ) No ( ) Yes

If Yes, Explain:

Are there cultural determinates that may influence needs: ( ) No ( ) Yes

Psych/Social Comments:

Name:

Medications List

Date Entered	Medication	Dose	Frequency	Related Diagnosis	Status	Comments

ADLS

Bathing

Activity Status:

( ) Person does not participate; another person performs all aspects of this task

( ) Requires continual help with all or most of this task

( ) Requires intermittent supervision and / or minimal assistance

( ) Totally Able

Need Met By:

[ ] Assistive Devices [ ] Formal Support [ ] Informal Support [ ] Unmet

Name of Person(s): Formal Support:

Comments:

Personal Hygiene

Activity Status:

( ) Person does not participate; another person performs all aspects of this task

( ) Requires continual help with all or most of this task

( ) Requires intermittent supervision and / or minimal assistance

( ) Totally Able

Need Met By:

[ ] Assistive Devices [ ] Formal Support [ ] Informal Support [ ] Unmet

Name of Person(s): Formal Support:

Comments:

Name:

Dressing

Activity Status:

( ) Person does not participate; another person performs all aspects of this task

( ) Requires continual help with all or most of this task

( ) Requires intermittent supervision and / or minimal assistance

( ) Totally Able

Need Met By:

[ ] Assistive Devices [ ] Formal Support [ ] Informal Support [ ] Unmet

Name of Person(s):

Formal Support:

Comments:

Mobility

Activity Status:

( ) Person does not participate; another person performs all aspects of this task

( ) Requires continual help with all or most of this task

( ) Requires intermittent supervision and / or minimal assistance

( ) Totally Able

Need Met By:

[ ] Assistive Devices [ ] Formal Support [ ] Informal Support [ ] Unmet

Name of Person(s):

Formal Support:

Comments:

Toileting

Activity Status:

( ) Person does not participate; another person performs all aspects of this task

( ) Requires continual help with all or most of this task

( ) Requires intermittent supervision and / or minimal assistance

( ) Totally Able

Need Met By:

[ ] Assistive Devices [ ] Formal Support [ ] Informal Support [ ] Unmet

Name of Person(s):

Formal Support:

Name:

Comments:

Eating

Activity Status:

( ) Person does not participate; another person performs all aspects of this task

( ) Requires continual help with all or most of this task

( ) Requires intermittent supervision and / or minimal assistance

( ) Totally Able

Need Met By:

[ ] Assistive Devices [ ] Formal Support [ ] Informal Support [ ] Unmet

Name of Person(s): Formal Support:

Comments:

Transfer

Activity Status:

( ) Person does not participate; another person performs all aspects of this task

( ) Requires continual help with all or most of this task

( ) Requires intermittent supervision and / or minimal assistance

( ) Totally Able

Need Met By:

[ ] Assistive Devices [ ] Formal Support [ ] Informal Support [ ] Unmet

Name of Person(s): Formal Support:

Comments:

Are changes in ADL functional capacity expected within 6 mths?: ( ) No ( ) Yes

If yes, describe.:

Overall ADLs Comments:

Totals

Informal Support: | Formal Support:

Assistive Devices: | Unmet Needs:

IADLS

Housework/Cleaning

Activity Status:

( ) Person does not participate; another person performs all aspects of this task

( ) Requires continual help with all or most of this task

( ) Requires intermittent supervision and / or minimal assistance

( ) Totally Able

Need Met By:

[ ] Assistive Devices [ ] Formal Support [ ] Informal Support [X] Unmet

Name of Person(s): | Formal Support:

Comments:

Self Administration of Medications

Activity Status:

( ) Person does not participate; another person performs all aspects of this task

( ) Requires continual help with all or most of this task

( ) Requires intermittent supervision and / or minimal assistance

( ) Totally Able

Need Met By:

[ ] Assistive Devices [ ] Formal Support [ ] Informal Support [ ] Unmet

Name of Person(s): | Formal Support:

Comments:

Shopping

Activity Status:

( ) Person does not participate; another person performs all

( ) Requires continual help with all or most of this task

( ) Requires intermittent supervision and / or minimal assistance

( ) Totally Able

aspects of this task

Need Met By: [ ] Assistive Devices [ ] Formal Support [ ] Informal Support [ ] Unmet

Name of Person(s): Formal Support:

Comments:

Laundry

Activity Status: ( ) Person does not participate; another person performs all aspects of this task ( ) Requires continual help with all or most of this task ( ) Requires intermittent supervision and / or minimal assistance ( ) Totally Able

Need Met By: [ ] Assistive Devices [ ] Formal Support [ ] Informal Support [ ] Unmet

Name of Person(s): Formal Support:

Comments:

Transportation

Activity Status: ( ) Person does not participate; another person performs all aspects of this task ( ) Requires continual help with all or most of this task ( ) Requires intermittent supervision and / or minimal assistance ( ) Totally Able

Need Met By: [ ] Assistive Devices [ ] Formal Support [ ] Informal Support [ ] Unmet

Name of Person(s): Formal Support:

Comments:

Prepare and Cook Meals

Activity Status: ( ) Person does not participate; another person ( ) Requires continual help ( ) Requires intermittent supervision ( ) Totally Able

Name:

performs all aspects of this task	with all or most of this task	and / or minimal assistance	

Need Met By: [ ] Assistive Devices [ ] Formal Support [ ] Informal Support [ ] Unmet

Name of Person(s): Formal Support:

Comments:

Handle Personal Business/Finances

Activity Status:

( ) Person does not participate; another person performs all aspects of this task	( ) Requires continual help with all or most of this task	( ) Requires intermittent supervision and / or minimal assistance	( ) Totally Able

Need Met By: [ ] Assistive Devices [ ] Formal Support [ ] Informal Support [ ] Unmet

Name of Person(s): Formal Support:

Comments:

Telephone

Activity Status:

( ) Person does not participate; another person performs all aspects of this task	( ) Requires continual help with all or most of this task	( ) Requires intermittent supervision and / or minimal assistance	( ) Totally Able

Need Met By: [ ] Assistive Devices [ ] Formal Support [ ] Informal Support [ ] Unmet

Name of Person(s): Formal Support:

Comments:

Are changes in IADL functional capacity expected within 6 mths?: ( ) No ( ) Yes

Name:

If yes, describe.:

Overall IADLs Comments:

Totals

Informal Support:

Formal Support:

Assistive Devices:

Unmet Needs:

Services Receiving

What formal services does the person currently receive?	(Check all that apply)	Provider
None Utilized	( ) No ( ) Yes	
Adult Day Health Care	( ) No ( ) Yes	
Caregiver Support	( ) No ( ) Yes	
Case Management	( ) No ( ) Yes	
Community-Based Food Program	( ) No ( ) Yes	
Consumer Directed In-home Services	( ) No ( ) Yes	
Congregate Meals	( ) No ( ) Yes	
Equipment/Supplies	( ) No ( ) Yes	
Escort	( ) No ( ) Yes	
Friendly Visitor/Telephone Reassurance	( ) No ( ) Yes	
Health Promotion	( ) No ( ) Yes	
Health Insurance Counseling	( ) No ( ) Yes	

Name:

Home Health Aide	( ) No ( ) Yes	
Home Delivered Meals	( ) No ( ) Yes	
Homemaking/Personal Care	( ) No ( ) Yes	
Hospice	( ) No ( ) Yes	
Housing Assistance	( ) No ( ) Yes	
Housekeeping/Chore	( ) No ( ) Yes	
Legal Services	( ) No ( ) Yes	
Mental Health Services	( ) No ( ) Yes	
Nutrition Counseling	( ) No ( ) Yes	
Occupational Therapy	( ) No ( ) Yes	
Outreach	( ) No ( ) Yes	
Personal Emergency Response System (PERS)	( ) No ( ) Yes	
Protective Services	( ) No ( ) Yes	
Respite	( ) No ( ) Yes	
Respiratory Therapy	( ) No ( ) Yes	
Senior Center	( ) No ( ) Yes	
Senior Companions	( ) No ( ) Yes	
Services For The Blind	( ) No ( ) Yes	
Shopping	( ) No ( ) Yes	

Skilled Nursing	( ) No ( ) Yes	
Social Adult Day Care	( ) No ( ) Yes	
Speech Therapy	( ) No ( ) Yes	
Transportation	( ) No ( ) Yes	
Other	( ) No ( ) Yes	

Informal Support Status

Does the person have a family, friends and/or neighbors who help or could help with care?: ( ) No ( ) Yes

Primary Contact Name:

Degree of involvement (Type of help/frequency):

Does the person appear to have a good relationship with this person?: ( ) No ( ) Yes

Explain/Describe:

Would the person accept help, or more help, from this person in order to remain at home and/or maintain independence?: ( ) No ( ) Yes

Explain/Describe:

Any factors that might limit this person`s involvement?:

[ ] Emotional Burden [ ] Family Responsibilities [ ] Finances [ ] Health Problems
[ ] Job [ ] Living Distance [ ] Physical Burden [ ] Reliability
[ ] Transportation

Would this person be considered the caregiver?: ( ) No ( ) Yes

Is caregiver relief needed for respite?: ( ) No ( ) Yes

Name:

If Yes, when?:

[ ] Afternoon
[ ] Day & Evening
[ ] Evening
[ ] Morning
[ ] Needs relief and would take it any time
[ ] Other
[ ] Overnight
[ ] Weekend

Which of these services could be provided as respite for the caregiver?:

[ ] Adult Day Services
[ ] Personal Care Level 1
[ ] Personal Care Level 2
[ ] In Home Contact & Support (Paid Supervision)

Would the caregiver like to receive information about other caregiver services?:

( ) No
( ) Yes

Secondary Contact Name:

Degree of involvement (Type of help/frequency):

Does the person appear to have a good relationship with this person?:

( ) No
( ) Yes

Explain/Describe:

Would the person accept help, or more help, from this person in order to remain at home and/or maintain independence?:

( ) No
( ) Yes

Explain/Describe:

Any factors that might limit this person`s involvement?:

[ ] Emotional Burden
[ ] Family Responsibilities
[ ] Finances
[ ] Health Problems
[ ] Job
[ ] Living Distance
[ ] Physical Burden
[ ] Reliability
[ ] Transportation

Would this person be considered the caregiver?:

( ) No
( ) Yes

Is caregiver relief needed for respite?:

( ) No
( ) Yes

If Yes, when?:

[ ] Afternoon
[ ] Day & Evening
[ ] Evening
[ ] Morning
[ ] Needs relief and would take it any time
[ ] Other
[ ] Overnight
[ ] Weekend

Name:

Which of these services could be provided as respite for the caregiver?:	[ ] Adult Day Services	[ ] Personal Care Level 1	[ ] Personal Care Level 2	[ ] In Home Contact & Support (Paid Supervision)
Would the caregiver like to receive information about other caregiver services?:	( ) No	( ) Yes		
Can other informal support(s) provide temporary care to relieve the caregiver(s)?:	( ) No	( ) Yes		
If yes, describe.:				
Does the person have any community, neighborhood or religious affiliations that could provide assistance?:	( ) No	( ) Yes		
If yes, describe who might be available, when they might be available and what they might be willing to do.:				
Comments:				
Overall Evaluation of Informal Support:	( ) Adequate, can expand if needed ( ) Temporarily Unavailable	( ) Adequate, could not expand	( ) Inadequate / Limited	( ) Other

Monthly Income

Name:

Poverty Level			# of people in household	
Sources of Income				
Source	**Individual Being Assessed**	**Person's Spouse**	**Other Family/ Household Income**	**Total Family/Household Income (Total Month / Total Year)**
SS Income				
Pension				
Rental				
Supp. SS Income				
Interest Income				
Dividend Income				
Salary Income				
Other Income				
Total Income				
Total Annual Income				
Comments				
Is client a veteran?	( ) No	( ) Yes		
Check if person will provide no financial information?	[ ]			
If checked, describe?				

Benefits/Entitlements

Income Related Benefits

Social Security:

SSI (*):

Railroad Retirement:

SSD:

Veteran's Benefits:

Entitlements

Medicaid Number:

Food Stamps (SNAP):

Public Assistance:

Health Related Benefits

Medicare Number:

QMB:

SLIMB/QI-1:

EPIC:

Medicare Part D:

Medigap Insurance/HMO:

Long Term Care Insurance:

Health Insurance:

Private Health Insurance:

Housing Related Benefits

Name:

SCRIE:		Section 8:	
IT 214:		Veteran Tax Exemption:	
Reverse Mortgage:		Real Property Tax Exemption (STAR):	
HEAP:		WRAP:	
Telephone Discount:		Aged STAR Exemption:	
Cable Discount:		Lifeline/PERS:	
Other:			

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

Require Counseling on Benefits/ Entitlements: ( ) No ( ) Yes

Benefits/Entitlements Comments:

Contacts List

Contact	Relation	Address	Home Phone	Work Phone	Mobile Phone	C-Giver	E-Contact	Status	Type

NEW YORK STATE OFFICE FOR THE AGING
2 Empire State Plaza, Albany, NY 12223-1251
Andrew M. Cuomo, Governor Corinda Crossdale, Acting Director

An Equal Opportunity Employer

PROGRAM INSTRUCTION	**Number: 16-PI-10**
	Supersedes: 15-PI-10
	Expiration Date:

DATE: **June 21, 2016**

TO: Area Agency on Aging Directors

SUBJECT: **2016 Financial Levels for EISEP and CSE Client Cost Share and Medicaid Eligibility Determination**

.....

ACTION REQUESTED: Effective, January 1, 2016 all Area Agencies on Aging (AAAs) and their contractors must:

- Use the instructions and figures in this Program Instruction in conducting client financial assessments to determine cost sharing amounts for Expanded In-home Services for the Elderly Program (EISEP) services and Community Services for the Elderly Program (CSE) funded EISEP-like services, and to determine potential Medicaid eligibility of clients in these programs.

PURPOSE:

- To inform AAAs of the 2016 financial levels that must be used in determining client cost sharing and potential Community Medicaid eligibility for clients receiving EISEP or CSE-funded EISEP-like services.

- To transmit the Client Cost Sharing Thresholds and Schedules – Effective January 1, 2016.

- To transmit an updated copy of the optional Financial Information and Client Agreement Form (FIF) for use in determining client cost sharing and potential Community Medicaid eligibility.

BACKGROUND: New York State Office for the Aging (NYSOFA) regulations governing EISEP and CSE-funded EISEP-like services require that income thresholds and cost share schedules be adjusted to reflect changes in the Consumer Price Index for all items between the third quarters of the preceding two calendar years. The regulations also prohibit AAAs from providing EISEP or CSE-funded services to individuals who can receive the same or similar services under other governmental funding sources, including Medicaid. Therefore, each year NYSOFA provides AAAs with updated information on income and resource allowances under Medicaid, as well as the updated figures relevant for determining client cost sharing.

Each AAA may either use the FIF or adapt it to collect additional local information or format to better suit local needs. A modified form must minimally include the information contained in the FIF.

SUMMARY OF CHANGES: The FIF has been updated to reflect current income and housing adjustment thresholds.

The income thresholds and cost share schedules are revised each year to reflect the increase in the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) (U.S., all items) between the third quarters of the current and previous calendar years. This year that is 0.0 percent. This zero percentage is the same as the Cost-of-Living Adjustment in Social Security benefits.

The EISEP income thresholds are an approximation of 150 percent of the 2016 federal poverty guidelines. They were calculated by applying the 0.0 percent Cost of Living Adjustment to 150 percent of the 2016 poverty income guidelines.

The following figures reflect the changes:

- Income Thresholds are $1,485 and $2,003 per month for an individual and couple, respectively;

- Housing Adjustment Thresholds are $594 and $801 per month for an individual and couple, respectively; and

- Maximum Housing Adjustment Thresholds are $594 and $801 per month for an individual and couple, respectively.

Expanded In-home Services for the Elderly Program CLIENT COST SHARING THRESHOLDS AND SCHEDULES

Effective January 1, 2016

A. Monthly Income Thresholds

INDIVIDUAL = $1,485

COUPLE = $2,003

B. Housing Adjustment Thresholds

1) To be eligible for a housing adjustment, average monthly housing expenses must be more than the following:

INDIVIDUAL = $594

COUPLE = $801

2) The amount of the housing adjustment cannot be more than the following maximum amounts:

INDIVIDUAL = $594

COUPLE = $801

C. Cost Share Rate Schedule

INDIVIDUAL				COUPLE			
Adjusted Income			Fee Rate	Adjusted Income			Fee Rate
$0			0%	$0			0%
$1	to	$52	5%	$1	to	$70	5%
$53	to	$104	10%	$71	to	$141	10%
$105	to	$156	15%	$142	to	$211	15%
$157	to	$208	20%	$212	to	$281	20%
$209	to	$261	25%	$282	to	$351	25%
$262	to	$313	30%	$352	to	$422	30%
$314	to	$365	35%	$423	to	$492	35%
$366	to	$417	40%	$493	to	$562	40%
$418	to	$469	45%	$563	to	$632	45%
$470	to	$521	50%	$633	to	$703	50%
$522	to	$573	55%	$704	to	$773	55%
$574	to	$625	60%	$774	to	$843	60%
$626	to	$677	65%	$844	to	$913	65%
$678	to	$729	70%	$914	to	$984	70%
$730	to	$782	75%	$985	to	$1,054	75%
$783	to	$834	80%	$1,055	to	$1,124	80%
$835	to	$886	85%	$1,125	to	$1,194	85%
$887	to	$938	90%	$1,195	to	$1,265	90%
$939	to	$990	95%	$1,266	to	$1,335	95%
* More than		$990	100%	* More than		$1,335	100%

* Or eligible for Medicaid.

The 2016 Medicaid income and resource levels established by the New York State Department of Health (NYSDOH) for determining Community Medicaid eligibility income and resource levels remain the same as last year and are as follows:

- Income levels are $825 and $1,209 per month for an individual and couple, respectively; and
- Resource levels are $14,850 and $21,750 for an individual and couple, respectively.

All changes in the housing adjustment thresholds, income thresholds and Community Medicaid allowable resource and income levels have been inserted in the revised form.

Area Agencies on Aging (AAAs) that use a client assessment tool that is part of their computer software and use a paper document to conduct the financial assessment, may want to contact their software vendor to ask for instruction in using their product's electronic financial form. When using any electronic forms provided by a vendor, AAAs must use the most recent version of that form and ensure that it reflects the current year's requirements.

PROGRAMS AFFECTED:

☐ Title III-B ☐ Title III-C-1 ☐ Title III-C-2

☐ Title III-D ☐ Title III-E ☒ CSE ☐ WIN ☐ Energy

☒ EISEP ☐ NSIP ☐ Title V ☐ HIICAP ☐ LTCOP

☐ Other:

CONTACT PERSON:
Eileen Griffin

TELEPHONE:
(518) 408-1652

Email: EISEP@aging.ny.gov

Expanded In-Home Services for the Elderly Program Financial Information & Client Agreement

1 Case Information

1. Name: _____ _____ _____
   Last First M.I.
   For a married couple when both are participating, enter name of second person:

   Name: _____ _____ _____
   Last First M.I.

2. ☐ Initial Assessment ☐ Reassessment

3. Sources of Information *(Check all that are applicable)*
   ☐ Person(s) ☐ Spouse ☐ Financial Records
   ☐ Other (*specify)*_____

4. ☐ Person(s) will provide no financial information **Skip to Sections 4, then 6D, F and G**

5. Financial Assessment Prepared by:_____/_____
   Name Date

2 Monthly Income

1. Source

1.	**A.** Person (Individual or Couple/1Client)	**B.** Person's Spouse	**C.** Couple/Both Clients
	Amount of Monthly Income		
a. Social Security			
b. Supplemental Security Income: (SSI)			
c. Pension/Retirement Income: (Private/Gov't, veterans benefits, annuities, IRAs, etc.)			
d. Interest: (Monthly Income)			
e. Dividends: (Monthly Average)			
f. Salary/Wages			
g. Other (Specify)			
h. Other (Specify)			
2. Total Monthly Income (total sum of lines a.-h.)			
3. Total Monthly Income of Couple/1 Client (*Sum of 2A 2B*)			
4. Amount of non-client spouse's income not available for mutual needs			
5. Net Monthly Income Available: (*Line 3 minus Line 4)*			

☐ *Check if person receives SSI and is automatically Medicaid certified. **Refer to LDSS**.

☐ Check if person's care plan includes no EISEP or CSE-funded EISEP-like services, other than case management. **SKIP to Section 5.**

☐ Check if Monthly Income is below the income threshold (for an individual, Line 2, Column A is $1,485.00 or less; for a couple, Line 2 Column C or Line 5, combined Columns A & B is $2,003.00 or less). **Skip to Section 4, Line 1, and enter "0" as Fee Rate.**

3

Housing Expenses & Income Adjustment

1. Monthly rent or mortgage payment _____

2. Other **monthly** expenses allowable as adjustment, paid from person's or spouse's Income but not included in rent or mortgage Payment:

   a. Electricity……. _____
   b. Other heating & cooking fuels…….. _____
   c. Telephone installation & local usage…….. _____
   d. Water & sewage……... _____
   e. Property taxes…… _____
   f. School taxes…….. _____
   g. Other (Specify)……. _____
   h. **Total** *(Lines 2a through 2g)*…… _____

	Amount	
	A. Individual	**B.** Couple
3. Total allowable housing expense *(Lines 1 + 2h)*		
4. Housing adjustment threshold	**-$594.00**	**-$801.00**
5. Excess housing expenses *(Line 3 minus 4)*		
6. Maximum adjustment	**594.00**	**$801.00**
7. Net Monthly Income *(from Section 2, Line 2 or 5)*		
8. Adjustment *(Enter either Line 5 or Line 6, whichever is less)*		
9. Monthly income after deduction of excess housing costs *(Line 7 minus Line 8)*		
10. Amount of income threshold	**$1,485.00**	**$2,003.00**
11. Adjusted Income and Maximum Monthly Fee *(Line 9 minus Line 10)*		

4

Cost Share Calculation

1. **Fee rate** for service(s) or items (from cost share rate schedule based on Section 3, line 11 or instructions at bottom of Section 2)_____%

2. **Services(s) Recurring Monthly**

A	B	C	D	E
Service	# of Units Each Time Service is Provided	# of Times/Month	Unit Cost	Monthly Cost
	2.a. Total Cost for one month			$

3. Service(s) Recurring Other than Monthly

A	**B**	**C**	**D**	**E**	**F**
Service	# of Units Each Time Service is Provided	Unit Cost	Cost	Frequency	Monthly Cost
	3.a. Total Cost for one Month				$

4. One Time Services, Goods and/or Items

A	**B**	**C**	**D**
Service/Good/Item	Total Cost	Months Remaining in Care Plan*	Monthly Cost
	4.a. Total Cost for one Month		$

*Based on when service/good/item is expected to be received.

5. **Total Monthly Cost**
   a) (Sum of **Section 4**: 2.a., 3.a., & 4.a.) $_____
   b) Fee Rate (**Section 4**: Line 4.1, above) _____%
   c) Fee for one month (Total cost X rate) $_____
   d) Maximum monthly fee (**Section 3**: Line 11) $_____
   e) Estimated monthly cost share: Use the lesser amount among c or d above) $_____

5 **Community Medicaid Pre-Screen**	☐ Check if household includes one or more person in addition to the person and spouse ☐ Check if person is under age 65 and is not disabled *If either or both of the above boxes are checked, **Skip to Section 6**. Consult LDSS if you believe person or couple is Medicaid eligible*.

RESOURCES		Single Person Household	Two Person Household	**2016 Allowable Resources** **1 Person: $14,850** **2 Persons: $21,750**
1. **Liquid Resources**	a. Checking Accounts	$	$	☐ Line 3 exceeds Allowable Resources. Person appears to be ineligible for Medicaid.* **Skip to Section 6.** *For all others, continue to Line 4.*
	b. Savings Accounts	$	$	
	c. Other Cash Accounts	$	$	
	d. Stocks, bonds, mutual funds, etc.	$	$	
	e. Other liquid assets (IRAs, etc.)	$	$	
	f. Total liquid assets	$	$	
2. Subtract $1,500 per person to be set aside as a burial fund		-$1,500	-$3,000	
3. Subtotal of Line 1.f minus Line 2				
4. **Real Property**: Net value of real property (other than exempt home and an automobile). Include second home, land, rental property, etc.				
5. Subtotal (Line 3 + Line 4)				☐ Line 5 exceeds Allowable Resources. Person appears to be ineligible for Medicaid.* **Skip to Section 6**. *For all others, continue to Line 6.*
6. **Life Insurance**				
a. Face value of life insurance ($1,500 or less per person)				
b. Cash value of life insurance (If face value is over $1,500 per person)				
7. Subtotal (Line 5 + Line 6a or 6b)				
INCOME				☐ Line 7 exceeds Allowable Resources. Person appears to be ineligible for Medicaid.* **Skip to Section 6.** *For all others, continue with Line 8.* ***Note: Viable medical bills may reduce excess resources – see instructions.**
8. Enter total amount from Section 2 Line 2 or 5 in appropriate column.				
Subtractions				
9. Health Insurance Premiums	$			
10. Income Exclusion	$ **20.00**			
11. Total Subtractions	$	-	-	
12. Remaining net income (Line 8 minus Line 11)				
13. Net monthly Medicaid income level		**$825**	**$1,209**	
14. If Line 12 equals/exceeds Line 13 enter difference				
☐ Line 13 exceeds Line 12. Refer person to LDSS for Medicaid eligibility determination and **Skip to Section 6.** For all others continue with Line 15.				
MEDICAL EXPENSES				
15. Estimated monthly cost of Medicaid reimbursable services from the care plan.				
16. Estimated other medical expenses *(list type and monthly amount)*				
17. Total medical expenses (sum of Lines 15 and 16)		$	$	

If Line 17 equals or exceeds Line 14 and if the person or couple has enough income above the amount needed for living expenses to pay the Excess Income Program liability noted on Line 14 refer to LDSS for complete eligibility determination. **Continue with Section 6.**

EISEP or CSE Client Agreement

Name(s) of Client(s):_____

Time Period Covered by this Agreement:_____ to _____

A. Agreement – No Cost Share

☐ Check box if this section is part of the agreement.

I understand that, based on the information I have provided, I am not required to pay a fee for my EISEP or CSE EISEP-like services for the period covered by this agreement.

B. Agreement – Cost Share

☐ Check box if this section is part of the agreement.

I agree to pay a fee for the services, goods and/or items I receive under EISEP/CSE for the period covered by this agreement. This fee will not exceed _____% of the cost of services I receive in a month or $_____, whichever is less. This does not include the cost of case management, which is free.

The estimated fee I will pay each month is $_____, based on the services, goods and/or items I expect to receive from EISEP/CSE. However, I will not be charged for any services I do not actually receive.

C. Agreement – Cost Share for Potential Medicaid Clients

☐ Check box if this section is part of the agreement.

I understand that I appear to be eligible for Medicaid and I understand that I must apply for Medicaid. During the Medicaid application and determination process, I request that the EISEP/CSE services, as set in my care plan, be provided to me.

I understand that I am responsible for the cost of these services in the amount of $_____ per month for the period covered by this Agreement. However, I will not be charged for any services I do not actually receive. I understand that if I am found Medicaid-eligible, Medicaid will pay for similar in-home services. I understand that I will be under no further financial obligation for Medicaid, this agreement will be ended, and a new agreement will be drawn based on my income, housing costs and living arrangements. This new agreement may, if necessary, include a cost share for the period of this agreement.

D. Agreement – Pay Full Cost, No Financial Information

☐ Check box if this section is part of the agreement.

I decline to provide the information required for this form. I believe my income and resources make me ineligible to receive similar in-home or case management services under Medicaid or any other government program. I understand that by refusing, I am ineligible to receive cost-share assistance under EISEP/CSE. I elect to receive the services for which I am eligible by this agreement and to pay the full cost of the services, $_____per month, for the period covered by this agreement. However, I will not be charged for any services I do not receive.

I understand that should I decide to provide all of the information requested on this form, I have the opportunity to request and receive a re-determination of the amount of the fee(s) I am required to pay. To request this, I will contact _____ at _____. A re-determination under this section shall take effect no earlier than the date of the new agreement.

E. Affirmation of Financial Information

I, _____, affirm that the financial information given here is true and correct to the best of my knowledge and agree that this information may be checked as necessary. I realize that any false statements or misrepresentation knowingly made by me in connection with this financial assessment may result in my being ineligible for services.

I understand that future changes in income, housing expenses, living arrangements, or medical expenses could affect this agreement. I agree to notify _____ at _____ of any changes if they occur. I understand that if changes occur, my cost share may be recomputed from the time of the change. If I have overpaid, I will be reimbursed in full by the local Office for the Aging. If I have underpaid, I will pay the amount owed. If a mistake is found, I understand that my cost share may be recomputed from the time services began.

I have been fully informed of the policy and procedure for paying fees and understand that failure to pay may make me ineligible to receive services under EISEP or CSE.

F. Rights

I have been informed of my rights under EISEP and CSE and have received a copy of these rights. My case manager has explained them to me, answered my questions, and assured me that any other questions will be answered at any time I wish.

I have been informed of my right to contest the local Office for the Aging's determination of the amount of my cost share. This includes my right to request a hearing and to request a settlement conference to resolve any disagreement informally and my right to appeal a local Hearing Officer's decision to the New York State Office for the Aging.

G. Care Plan Acceptance

The Case Manager must review the Care Plan with each client and/or their authorized representative.

I accept the Care Plan

☐ Yes ☐ No (Explain)

_____ / _____

Client/Representative Signature **Date**

_____ / _____

Client/Representative Signature **Date**

_____ / _____

Case Manager **Date**

NY Connects Organization:
Intake Worker's Name:
Date:

Part One

Contact and Demographic Information

A. Mode of Contact:

□ Face to Face
□ Phone Call
□ E-mail
□ Other

B. Type of Contact:

□ Consumer
□ Professional/provider
□ Caregiver/family
□ Veteran/Service Member
□ Other
□ Unknown

C. Source Type:

□ Self
□ Friend, Neighbor, or Relative
□ Radio
□ Brochure
□ Local Newspaper
□ Local Agency or Human Services Provider
□ Website/Webpage
□ Television
□ Congregate Setting Provider
□ School
□ Physician
□ Veterans Administration
□ Hospital
□ Institution
□ Re-Entry Coordinator
□ Other

D. Consumer Demographics:

- Name:
- Legal Address:
- Current Address (if different):
- Phone Number:
- Date of Birth:
- Gender: Female □ Male □ Unknown □
- Marital Status:
- Language Requirements:

- Emergency Contact:

E. What is the consumer's race or ethnicity (optional)?

□ White
□ Black/African American
□ Asian
□ Native Hawaiian/Other Pacific Islander
□ American Indian/Native Alaskan
□ Hispanic or Latino

F. What are the consumer's current living arrangements?

□ Alone
□ With spouse/parents
□ With relatives
□ With non-relatives (friends/neighbors)
□ In a congregate setting

G. Information Initially Requested: *(see Part C of aggregate reporting tool for specific services that pertain to each of the following categories)*

1.) Children Specific
2.) Consumer and Caregiver Supports
3.) Facility Based Services
4.) Health and Wellness
5.) Home Based Services
6.) Home Modifications and Repairs
7.) Insurance/Benefit Information and Counseling
8.) Legal Services
9.) Mental Health, Cognitive Status, Support Groups/Counseling
10.) Nutrition
11.) Personal Finance and Tax Assistance
12.) Potential Abuse
13.) Prescription/Medications
14.) Protective/Prevention
15.) Residential/Housing Options and Supports
16.) Transportation
17.) Other

Comment (if necessary):

H. Assistance Provided:

1.) Connected/Linked Consumer with Agencies, Providers or Programs
2.) Contact With Friends, Family or Others to Better Assist the Consumer
3.) Off-Site Visit Conducted
4.) Options Counseling to Consumer/Caregiver
5.) Personalized Packets Distributed/Mailed
6.) Screening for Medicaid and other public LTC Programs
7.) Short Term Case Management/Care Coordination
8.) Telephone Follow-up Delivered
9.) Translation Services Provided
10.) Application Assistance
    10.1) Submitted LIS Application
    10.2) Submitted MSP Application
    10.3) Assisted with Medicaid Application
    10.4) Assisted with SNAP (Food Stamp) Application
    10.5) Assisted with HEAP Application
    10.6) Assisted with Application for Publically Funded Services/Programs
11.) Assisted with Discharge from a Hospital
12.) Assisted with Discharge from a Nursing Home or Subacute Facility
13.) Referral to Aging Services Network
14.) Referral to CDSME
15.) Referral to Disability Organization/Services
16.) Referral to Early Intervention Services
17.) Referral to Independent Living Center
18.) Referral to OPWDD
19.) Referral to OMH
20.) Assisted Re-entry coordinator with individuals with LTSS needs

Comment (if necessary):

Part Two

Consumer Needs and Abilities

A. Which of the Following Does the Person Need Assistance With? (check all that apply)

ADLs:
Personal Hygiene/ Dressing/ Mobility/ Transfer/ Toileting/ Eating/ Bathing

IADLs:
Housework or Cleaning/ Shopping/ Laundry/ Transportation/ Prepare and Cook Meals/ Self Administration of Medications/ Handle Personal Business or Finances/ Use of Telephone

Formal and Informal Support Status

A. Does the consumer have family, friends, and/or neighbors who are currently helping with care?

Primary Informal Support:
- Name:
- Phone:

B. What formal services does the consumer currently receive?

Functional Capacity and Health Status

A. Does the consumer have a chronic illness and/or disability?
Such as:
Alcoholism/ Alzheimer's/ Anorexia/ Arthritis/ Cancer/ Colitis/ Colostomy/ Congestive Heart Failure/ Dehydration/ Diabetes/ Digestive Problems/ Diverticulitis/ Fractures (recent)/ Gall Bladder Disease/ Hearing Impairment/ Heart Disease/ High Blood Pressure/ Liver Disease/ Low Blood Pressure/ Muscular Dystrophy/ Osteoporosis/ Parkinson's/ Renal Disease/ Respiratory Problems/ Seizure Disorders/ Speech Problems/ Stroke/ Swallowing Difficulties/ Technology Dependent/ Ulcer/ Urinary Tract Infection/ Visual Impairment/ Other (specify)

B. Does the consumer appear, demonstrate, and/or report any of the following?

Alert/ Cooperative/ Dementia/ Depressed/ Disruptive/ Hallucinations/ Impaired Decision Making/ Lonely/ Memory Impairment/ History of Mental Health Treatment/ Physical Aggression/ Sleeping Problems/ Verbal Disruption/ Worried or Anxious/ Other (specify)

Financial Status

A. What is the consumer's approximate monthly income (e.g.: Social Security, pension, working income, etc)?

B. What are the consumer's resources/assets (e.g.: stocks, bonds, trust funds, CDs, bank accounts, etc)?

C. Does the consumer currently receive?
- □ Veterans Pensions or Health Care
- □ Social Security or SSI Payments
- □ Medicaid
- □ Medicare
- □ Long Term Care Insurance
- □ Railroad Pension
- □ Unknown
- □ Other

Action Taken

A. Information Provided:

1) Children Specific
Child Care Provider Referrals/ Early Intervention for Children with Disabilities or Delays/ Special Education Assessment/ Kinship Care

2) Consumer and Caregiver Supports
Advocacy/ Assistive Technology Equipment/ Caregiver Training/ Case or Care Management/ Centers for Independent Living/ Condition Specific Rehabilitation Services/ Friendly Visiting/ Outreach Programs/ Respite Care/ Senior Centers/ Vocational Rehabilitation

3) Facility Based Services
Adult Day Health Programs/ Adult Day Programs (Social)/ Nursing Facilities

4) Health and Wellness
Health Care Referrals/ Substance Abuse/ Oral Health Issues/ Wellness Programs/ Chronic Disease Self-Management Programs/ Falls Prevention Programs

5) Home Based Services
Companionship/ Home Delivered Meals/ Home Health Care/ In-Home Attendants for People with Disabilities/ Personal Care/ Personal Emergency Response Systems/ Private Duty Nursing/ Telephone Reassurance

6) Home Modification and Repairs
Home Barrier Evaluation/Removal/ Home Rehabilitation/Repair Services/ Home Maintenance Services/ Yard Work

7) Insurance/Benefit Information and Counseling
Health Insurance Information and Counseling/ Long Term Care Insurance Information or Counseling/ Managed Health Care Information/ Medicare Information or Counseling/ Medicaid (general info)/ Veteran Benefits Assistance/ Welfare Rights Assistance/ Social Security Retirement Benefits

8) Legal Services
Legal Services (General Legal Services Related Questions/ Adult Guardianship Assistance/ Advance Medical Directives/ Child Guardianship Assistance

9) Mental Health, Cognitive Status, Support Groups/Counseling
Mental Health Issues/ Aging or Older Adult Support Groups/ Caregiver or Care Receiver Workgroups/ Caregiver Counseling/ Disability Related Support Groups/ Specialized Counseling Services/ Dementia

10) Nutrition
Congregate Meals or Nutrition Sites/ Food Stamps (SNAP)/ Nutrition Assessment Services/ Nutrition Education/ Food Pantries/ Wellness Programs/ WIC

11) Personal Finance and Tax Assistance
Personal Finances or Budget Counseling/ Tax Preparation Assistance/ Tax Information/ Property Tax Exemption Information

12) Potential Abuse (As Per NYS Social Service Law)
Physical Abuse/ Sexual Abuse/ Financial Exploitation/ Active and Passive Neglect/ Self Neglect/ Domestic Violence/ Other (e.g. Abandonment)

12.1) Abuse, Neglect, Exploitation
Referred to Adult Protective Services/ Referred to Police Agency/ Referred to Domestic Violence Service Provider/ Referred to Child Protective Services/ Referred to Other/ Not Referred

13) Prescriptions/Medications
Government Subsidized Prescription Drug Benefits/ Prescription Drug Patient Assistance Programs/ Prescription Medication Services/ Prescription Expense Assistance

14) Protective/Preventative
Adult Protective/ Children's Protective Services/ Elder Abuse Reporting/ Consumer Fraud Reporting

15) Residential/Housing Supports and Options
Adult Residential Care Homes/ Assisted Living Facilities/ Congregate Living Facilities/ Low Income – Subsidized Rental Housing/ Naturally Occurring Retirement Community Programs (NORCs)/ Utility Payment Assistance/ Weatherization Programs/ Residential Housing Options/ Housing Issues/ Homelessness

16) Transportation
Automobile – Van Adaptations/ Disability Related Transportation/ Escort Programs/ Medical Transportation/ Senior Ride Programs

17) Other
Hospice/ Household Safety Education/ Interpreter Registries/ Activities of Daily Living Assessments/ Employment/ Volunteerism/ Other

B. Assistance Provided:

1.) Connected/Linked Consumer with Agencies, Providers or Programs
2.) Contact with Friends, Family or Others to Better Assist the Consumer
3.) Off-site Visit Conducted
4.) Options Counseling to Consumer/Caregiver
5.) Personalized Packets Distributed/Mailed
6.) Screening for Medicaid and Other Public LTC Programs
7.) Short Term Case Management/Care Coordination
8.) Telephone Follow-up Delivered
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    10.3) Assisted with Medicaid Application
    10.4) Assisted with SNAP (Food Stamp) Application
    10.5) Assisted with HEAP Application
    10.6) Assisted with Application for Publically Funded Services/Programs
21.) Assisted with Discharge from a Hospital
22.) Assisted with Discharge from a Nursing Home or Subacute Facility
23.) Referral to Aging Services Network
24.) Referral to CDSME
25.) Referral to Disability Organization/Services
26.) Referral to Early Intervention Services
27.) Referral to Independent Living Center
28.) Referral to OPWDD

Comment (if necessary):

C. Problems/Issues to be Referred:

D. Referred To:

Balancing Incentive Program (BIP) Caregiver Support Program
Questions and Answers
January 2016

Section 1. ADMINISTRATION AND MONITORING	
Question	**Response**
1. Can you provide a list of the ways the AAA may use these funds?	The AAA may expend up to 10 percent to administer the program, which includes staffing to administer the program. In addition to the 10 percent administrative cost described above, the AAA may expend dollars for staffing to implement programs under this grant as outlined in Section 4 of 15-PI-03 (revised).
2. How will this program be monitored?	The program will be monitored following the OAA Title III-E Caregiver Program guidelines. The AAA must maintain and have available for review the information contained in the **Balancing Incentive Program (BIP) Caregiver Support Program Caregiver/Care Receiver Required Information Form** (revised) included as an attachment to 15-PI-03 (revised). This form will be referred to in future answers as the BIP Caregiver Program Required Information Form.
3. Would we use the same homecare providers used through our III-E program?	YES. You may use the same home care providers as used through your OAA Title III-E program.
4. Does the grant require a sustainability plan?	NO. These funds are for a limited time period – all funds must be encumbered by June 30, 2017 and vouchered for by August 31, 2017. **No vouchers will be accepted beyond August 31, 2017.**
5. Our OFA does MA home care referrals; 'pushing' this type of client to the Nursing Home Transition and Diversion (NHTD) Waiver Program. If spend down, do a pooled trust. How do these things relate?	If the Caregiver is receiving assistance through the NHTD Waiver, these benefits must be maximized first and the Caregiver's unmet need/request for services documented in the BIP Caregiver Program Required Information Form.
6. What if we opt not to apply for these funds?	If your county opts not to apply for these funds, please send notification to Caregiver@aging.ny.gov and cc Karen Iovino @ karen.iovino@aging.ny.gov no later than two weeks from the date that 15-PI-03 (revised) is distributed.
7. Is this one year of funding or is there any future funding?	This funding is available through June 30, 2017.
8. What will be the revised due date to apply?	The response due date is identified in 15-PI-03 (revised).
9. Who is population in allocation schedule?	The population in the allocation schedule is the 60 plus population as used for the OAA Title III-E Caregiver Program. However, the BIP Caregiver Support

	Program is open to caregivers and care receivers age 18 and over who meet specified eligibility requirements identified in 15-PI-03 (revised).

Section 2. Data Collection and Reporting	
Question	**Response**
1. What forms/assessment tools are required?	BIP Caregiver Program Required Information Form is **required for all** program participants. - The AAA must **fully** complete this Form, and the Caregiver must sign the attestation on page three of this Form. - This Form must be maintained and available for monitoring/audit purposes (see Section 1, Question 2). For a Caregiver to be eligible for Respite and/or Supplemental Services, the Caregiver attestation may serve as documentation that the Care Receiver meets the cognitive, mental, Activities of Daily Living (ADL), or Instrumental Activities of Daily Living (IADL) functional limitations, as defined below and on the BIP Caregiver Program Required Information Form. • A person who 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; OR • A person who has two ADL needs (eating, dressing, bathing, toileting, mobility, personal hygiene and transferring from bed or chair) without substantial human assistance, including verbal reminding, physical cueing, or supervision; OR • A person who has two IADL needs (housekeeping, shopping, preparing meals, managing money, laundry, using transportation, telephoning and taking medication). For information about the Care Receiver: A UAS-NY (completed for a younger person), COMPASS, or other Minimum Data Set (MDS) Assessment that was completed within the past six months may be reviewed and used to fill out the BIP Caregiver Program Required Information Form, or it may be completed by interviewing the Caregiver.

	Minimum Data Set Assessment (COMPASS or similar instrument per 97-PI-01) must be completed if a service provided as Respite and/or a Supplemental Service is: • Personal Care Level 1 and/or 2 • Case Management • Home Health Aide Services • Home Delivered Meals • Social or Medical Day Care.
2. What instrument will we use to enter the data into our System – SAMS, Peer Place, etc.	Data may be entered from the BIP Caregiver Program Required Information Form. If a COMPASS, UAS-NY or other form has also been completed, the additional data found on those forms should also be entered into the System.
3. After registering a Caregiver & Care Receiver, is there follow-up monitoring required?	The follow up and monitoring required for this program should follow your current practice for the OAA Title III-E program.
4. The standard assurances say that state vouchers are to be used, but it was verbalized that federal claims forms are to be used. Are vouchers and claims forms different from each other (I'm not a fiscal person)	State voucher forms are to be used.

Section 3. ELIGIBILITY	
Question	**Response**
1. What will be acceptable forms of Medicaid status verification? What method will the AAA be able to use to verify Medicaid status of the Care Receiver?	After documenting the identity of the Caregiver and Care Receiver, the AAA documents the verification of Care Receiver's Medicaid status as follows on the BIP Caregiver Program Required Information Form: Verification used for Medicaid status: 1. Information seen on the Eligibility Card (formerly MA card) 2. AAA calls the LDSS/HRA to confirm eligibility. 3. AAA keeps a record/documentation of the Care Receiver Eligibility Card information and the date and person at the LDSS/HRA who confirmed MA eligibility.
2. The Medicaid recipient receives a written notice of decision from DSS which confirms that the person has Medicaid. Can this be used as the form of verification to be eligible?	Please use method described in response to question 1 above.
3. The HIICAP Coordinator has access to the Medicaid system and the AAA can call DSS and get the required information. Is it the CIN# you're looking for or another number?	Follow procedures as outlined in response to question 1 above. Do **not** call the HIICAP Coordinator to verify Medicaid status. (The CIN# does indicate or correspond with Medicaid eligibility).
4. Is it possible that we could provide services only to have the expenses denied because a judgment is made that Medicaid services were not maximized, and who would make that decision? How will we be able to determine if the Care Receiver has maximized the Medicaid benefits for a particular service? How do we know they have exhausted all benefits?	It is a possibility that reimbursement for services provided through this grant could subsequently be denied if a judgment is made that not all public benefits were maximized first. Any organization with the designated authority or jurisdiction to make such a determination would have this power. **To determine if the Care Receiver has maximized Medicaid benefits it is important to follow the documentation process described below.** The AAA documents that the Caregiver has maximized all public benefits (including Medicaid) for his/her Care Receiver as follows on the BIP Caregiver Program Required Information Form: • Document Care Receiver's program enrollment through the Caregiver account and attestation, the local Department of Social Services (DSS), Managed Long Term Care (MLTC) or other available sources. • Document that the public benefit services currently being received do not meet the Caregiver's expressed need(s)/request for service(s). • Document the Caregiver's unmet needs that correspond with the services this program offers as outlined in Section 4 of 15-PI-03 (revised).

5. Does "maximizing Medicaid benefits" include applying for and accessing any Medicaid waivered services for which the Care Receiver may be eligible?	YES.
6. What Caregivers are eligible to receive services under this program? Is there an age requirement? Is the Program limited to Caregivers of Care Receiver aged 60 and older?	Eligible Caregivers are adults aged 18 and older, including family members, who are providing unpaid direct care and/or support to a care recipient eligible to receive services and supports under this Program. The Care Receivers are adults aged 18 and older and must be Medicaid eligible in order for the Caregiver to receive any services through this Program. This includes: 1. All Caregivers of dual eligible clients (those clients currently served by AAAs/or on the waiting list who have been identified as receiving health insurance through Medicaid and are receiving or on a wait list for one or more long term service and/ or support through the AAA). 2. All Caregivers of individuals receiving Medicaid Managed Long Term Services and Supports who are in spend down. 3. NY Connects referrals that meet the description in Section 3 Questions 1.or 2.
7. Does the eligible population include Medicaid clients with a spend-down?	YES.
8. Can a recent UAS plus the attestation replace the Required Information Form?	NO. If a UAS-NY assessment, or a COMPASS was completed within the past six months, it may be reviewed and used to fill out the BIP Caregiver Program Required Information Form, which must be maintained by the AAA for monitoring purposes.
9. If diagnosis is non-dementia related and we are talking about a younger person as the Care Receiver, what assessment would be required? Would they need to meet the same ADL/IADL measures?	For information about the Care Receiver: A UAS-NY (completed for a younger person), COMPASS, or other Minimum Data Set (MDS) Assessment that was completed within the past six months may be reviewed and used to fill out the BIP Caregiver Program Required Information Form, or it may be completed by interviewing the Caregiver. The ADL/IADL or cognitive or other mental impairment measures are a requirement for Respite and/or Supplemental Services. See Section 2. Question 1.
10. Would those involved with community based hospice care be eligible? Specifically, would Care Receivers be eligible for CBLTCS Respite as a supplement to hospice care through this funding?	YES. The same requirement applies that all public benefits must be maximized first and the Caregiver's documented **unmet** need could be addressed by the services offered through this program.
11. How is cognitive mental impairment determined?	The BIP Caregiver Program Required Information Form allows for Caregiver-provided information,

	medical assessment or other (e.g., the UAS-NY or COMPASS completed within the past six months).
12. Is there an income limit for Caregivers?	NO. There is no income limit for Caregivers.
13. How can ADLs/IADLs be confirmed. Will Caregiver be able to confirm?	The BIP Caregiver Program Required Information Form will note ADLs and IADLs, and the Caregiver Attestation can be used as confirmation.
14. How will we determine if the Care receiver has full Medicaid benefits or only in receipt of the Medicare Savings Program (MSP) benefit?	After documenting the identity of the Caregiver and Care Receiver, the AAA documents the verification of Care Receiver's Medicaid status as follows on the BIP Caregiver Program Required Information Form: Verification used for Medicaid status: 1.Information seen on the Eligibility Card (formerly MA card) 2. AAA calls the LDSS/HRA to confirm eligibility. 3. AAA keeps a record/documentation of the Care Receiver Eligibility Card information and the date and person at the LDSS/HRA who confirmed MA eligibility. MSP should not be used to verify eligibility.
15. If the Care Receiver is approved but waiting for MLTC to start services, are they eligible for services through this program for that waiting period?	YES. The following documentation process for program enrollment and unmet Caregiver need should be used: The AAA documents that the Caregiver has maximized all public benefits (including Medicaid) for his/her Care Receiver as follows on the BIP Caregiver Program Required Information Form: • Document Care Receiver's program enrollment through the Caregiver account and attestation, the local Department of Social Services (LDSS), Managed Long Term Care (MLTC) or other available sources. • Document that the public benefit services currently being received do not meet the Caregiver's expressed need(s)/request for service(s). Document the Caregiver's unmet needs that correspond with the services this program offers as outlined in Section 4 of 15-PI-03 (revised).
16. What if MLTC doesn't provide service because they know we have these BIP funds?	The AAA documents that the Caregiver has maximized all public benefits (including Medicaid) for his/her Care Receiver as follows on the BIP Caregiver Program Required Information Form: • Document Care Receiver's program enrollment through the Caregiver account and attestation, the local Department of Social Services (DSS), Managed Long Term Care (MLTC) or other available sources. • Document that the public benefit services currently being received do not meet the

	Caregiver's expressed need(s)/request for service(s) Document the Caregiver's unmet needs that correspond with the services this program offers as outlined in Section 4 of 15-PI-03 (revised).
17. How does this serve persons in Managed Care?	The BIP Caregiver Support Program is designed to provide increased community-based offerings to address **unmet** Caregiver needs, service gaps or barriers to receiving timely care.
18. A Care Receiver lives with the Caregiver and has Medicaid funded home care Monday thru Friday. The Caregiver has children and meets her mother's needs in the evening and on the weekend. Could we use the BIP Caregiver funds to pay for home care as Respite if the Caregiver wants to attend her child's game, concert, or just to attend a wedding on the weekend?	YES. The BIP Caregiver Support Program is designed to provide increased community-based offerings to address **unmet** Caregiver needs, service gaps or barriers to receiving timely care.
19. I am concerned about where we would find these clients.	A report from the NYSOFA Client Data System identifying eligible clients will be provided by the NYSOFA Reporting Unit upon request. Other sources may be: - Local DSS; - Behavioral health homes; - Specialty MA programs (e.g., HIV Population); - Community Care Transitions Program; - Long Term Care Councils.

Section 4. Services	
Question	**Response**
1. Is Case Management for Caregivers only or for Care Receivers also?	Case Management is an allowable expense for the Caregiver, and may be an allowable expense for the Care Receiver if the case management is for services for the Care Receiver that are Respite and/or Supplemental Services for the Caregiver.
2. If a COMPASS is completed for the Care Receiver to determine eligibility for services that will be a Respite or Supplemental Service for the Caregiver is the cost covered under this program? Would other tasks managing the services for the Care receiver be covered also as long as they are a Respite and/or a Supplemental Service for the Caregiver?	YES. Tasks managing the services and supports for the Care Receiver are allowable as long as they are a Respite and/or Supplemental Service for the Caregiver and this is documented.
3. Is consumer directed Respite using the EISEP model allowed? This would be helpful due to shortage of home care workers.	YES. Consumer-directed Respite is allowed, and such services must use the EISEP model when using the BIP Caregiver Support Program to fund the service.
4. Is overnight Respite an allowable service?	YES. However, ONLY non-institutional services are allowable through the BIP Caregiver Support Program. Therefore, overnight Respite is allowable in a Medical and/or Social Adult Day Center/Program if it is offered. A Nursing Home or other Institution is not allowable for this program.
5. What will be done for direct assistance to the Caregiver?	Through this program, Caregiver supports and training programs are available to directly assist the Caregiver.
6. Would costs of recruiting, vetting, training volunteers be allowed? For Finger printing? For Friendly Visiting for Respite?	YES. Recruitment, training and performing required background checks are allowable as a program expense as long as properly allocated and documented based on the trained volunteer's/staff's anticipated involvement in delivery of services under the BIP Caregiver Support Program.
7. Can funds be used for education and outreach?	YES.
8. Can funds be used for marketing?	NO. Funds can be used for targeted outreach, not for general advertising.

Section 5. Supplemental Services	
Question	**Response**
1. Would PERS be allowable?	NO. As specified in 15-PI-03 (revised), PERS is **not** an allowable expense under the BIP Caregiver Support Program.
2. Can you provide more specifics on Home Modifications? Would a de-humidifier be an acceptable purchase? Would appliance replacement/relocation be allowable under "Other?"	In order for these services to be allowable, they would need to be of demonstrated benefit to the Caregiver. In general, Home Modifications do not include improvements to the home (carpeting, roof repair, central air conditioning), which are not medically necessary or do not promote the participant's independence in the home or community. In general, allowable Home Modifications include installation of: - ramps - lifts: hydraulic, manual or electric, for porch, bathroom or stairs (lifts may also be rented if it is determined that this is more cost-effective) - widened doorways and hallways - hand rails and grab bars - automatic or manual door openers and doorbells Bathroom and kitchen modifications, additions or adjustments to allow accessibility or improved functioning, include: - roll-in showers - sinks and tubs - water faucet controls - plumbing adaptations to allow for cutouts, - toilet/sink adaptations - turnaround space changes/adaptations
3. May we provide a ramp If a Caregiver identifies it as a need that has not been met through NHTD waiver program but is needed for the Caregiver to move the Care Receiver?	The BIP Caregiver Support Program is intended to benefit the Caregiver. It may not be used for the Care Receiver in lieu of other Medicaid funding such as in an established Medicaid program if/when the Care Receiver is enrolled in the Program. For any expense(s) to be allowable, they must be a demonstrated benefit to the Caregiver.
4. Are congregate meal, HDM, and nutrition education/counseling services available only for the Caregiver? Or are there also situations where the Care Receiver would be eligible for these services?	YES. Congregate meals, home delivered meals, and nutrition education/counseling services are available to the Care Receiver through this program as Supplemental Service(s) to support and supplement the Caregiver.

If a Caregiver who meets all the qualifications for this program is receiving meals already, can they be funded through this program? If a client is currently on an MLTC and they do not provide home delivered meals, is HDM an acceptable service?	
5. What transportation services are eligible: -- For the Care Receiver when transportation is needed to provide Respite services (e.g. SADS)? -- For the Caregiver when transportation is needed to receive Caregiver support, training or counseling? – For the Caregiver when transportation is needed to receive Respite services (e.g. Care Receiver's care is provided at home and Caregiver needs to get out and, if so, where – shopping, hairdresser, visiting friends, congregate meals?) -- Can transportation include the purchase of gas cards or the reimbursement for cab fare for non-Medicaid funded trips (i.e., non-medical appointments)? Would it apply only for transportation for Care Receivers, or would it also include transportation for Caregivers (e.g., to attend trainings or for any other needed purpose)?	Per the specific questions asked, transportation services are available: YES. YES. YES. YES. Reimbursement for cab fare for non-Medicaid funded trips to non-medical appointments for services being provided in association with this program is allowable.

PROGRAM IMPLEMENTATION EXAMPLES:	
Situations where this program could be used: *These examples were provided by a AAA with the question, Would the following be possibilities:*	
Prorated cost of staff providing Caregiver support groups, training, counseling & case management. Can we buy food for Caregiver support groups or training events? Is it correct that funds may be given to contractors? We generally do not do direct services in Nassau County all our services are contracted out except for NY Connects. We will be depending upon our contracted agencies to deliver services such as counseling, training and support groups. If some of our staff were trained to provide support groups to Caregivers, is this considered administrative costs or service costs that can be vouchered for? We are assuming administrative costs would be monitoring, assessment, and fiscal costs. Is this correct? Are costs to train the trainers considered legitimate expenses? Are costs for advertising services such as flyers, costs associated with website updates etc. acceptable expenses? What about travel? We are hoping to provide onsite information and support groups to our target communities which would involve some car travel. Can we replenish our Caregiver resources-material, books? Local Alzheimer's Association to conduct an educational series called "Early Stage Engagement" – it is a series of educational sessions meant to provide answers to questions for people concerned about early-stage Alzheimer's disease or related dementia, and their Caregivers. This eight week series includes such topics as how to partner with your physician, legal and financial issues, maintaining a healthy attitude, and taking advantage of community resources.	YES. These are allowable expenses, except: General advertising is not allowable. Targeted outreach is an allowable use of funds. Transportation to carry out program activities is an allowable use of funds.

Is Alzheimer's Association Dementia Capable Training which is a community education program for Caregivers one hour each month on topics such as: Know The Ten Warning Signs, Communication, Managing Challenging Behaviors, Driving and Dementia, Role Changes and Transitions, Personal Care, Managing Grief and Guilt, etc. eligible for funding? These programs would be open to anyone but we would outreach to and target Caregivers whose Care Receiver was on Medicaid.	
Medicaid recipient needing no LTC services except for Caregiver Respite (in which case is the Care Receiver NOT required to maximize all available Medicaid benefits, even when the Care Receiver is eligible for Medicaid services that result in Caregiver Respite?)	YES. These are allowable expenses. DOH suggests to follow the documentation process for program enrollment and unmet Caregiver need (described in DOH's response to Section 3. Question 4.)
Caregiver needs a source of Respite through a service <u>not provided by Medicaid:</u> • Social Adult Day Services • Oversight and supervision (when not in receipt of a waiver providing this service) • Non-medical transportation for Care Receiver • Transportation for Caregiver to sources of Respite, support, training, counseling, case management, congregate meals • Hours/times/days beyond what Medicaid is providing (though once services are "maximized", will this still be a gap?)	YES. These are allowable expenses.
Caregiver needs a source of Respite through a service <u>not currently available through Medicaid</u>: • Wait period for homecare • Wait period for waivers • No Home and Community Support Services aides available for Medicaid waiver-covered oversight and supervision	YES. These are allowable expenses.