Case Identification

Assessment Date (mm/dd/yyyy) *:

Assessor Name:

Assessment Agency:

Reason for COMPASS Completion: ( ) Initial Assessment ( ) Reassessment

Next Assessment Date (mm/dd/yyyy):

HDM Recipient 6 Month Contact Date Due (mm/dd/yyyy):

Client Information

A. Person's Name

Last Name:

First Name:

Middle Name:

Preferred Name:

Gender Pronouns:

B. Address

Address Line 1:

Address Line 2:

City:

State:

Zip:

Town:

County:

C. E-mail

E-mail:

D. Telephone Numbers

Home:

Work:

Cell:

E. Social Security Number

Social Security No. (Last 4 digits only):

F. Marital Status

Marital Status: ( ) Divorced ( ) Domestic Partner or Signif Other ( ) Married ( ) Separated ( ) Single ( ) Widowed

G. Gender Identity

What is your current gender identity? (Check all that apply):

[ ] Female [ ] Male [ ] Transgender [ ] Gender Non-Binary

[ ] I am not sure of my gender identity [ ] I do not know what this question is asking

If Transgender:

( ) Transgender, male-to-female ( ) Transgender, female-to-male ( ) Transgender, gender nonconforming

H. Sex

On your original birth certificate, was your sex assigned as Male or Female?:

( ) Female ( ) Male

I. Gender

ACL Gender Reporting Requirement:

( ) Female ( ) Male ( ) Other

J. Birth Date

Birth Date (mm/dd/yyyy): Age:

K. Race/Ethnicity

Race:

[ ] American Indian / Native Alaskan [ ] Asian [ ] Black or African American [ ] Native Hawaiian / Other Pacific Islander

[ ] White - Hispanic [ ] White - Not Hispanic

Ethnicity:

( ) Hispanic or Latino ( ) Not Hispanic or Latino

L. Sexual Orientation

Which of the following best represents how you think about yourself?:

( ) Lesbian or Gay ( ) Straight (not lesbian or gay) ( ) Bisexual ( ) Not Sure

( ) Other ( ) Did Not Answer

M. Creed

Creed:

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

Other specify:

N. National Origin

National Origin:

O. 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
Yiddish:	[ ] Speaks	[ ] Reads	[ ] Understands orally
Bengali:	[ ] Speaks	[ ] Reads	[ ] Understands orally
Korean:	[ ] Speaks	[ ] Reads	[ ] Understands orally
Haitian Creole:	[ ] Speaks	[ ] Reads	[ ] Understands orally
Italian:	[ ] Speaks	[ ] Reads	[ ] Understands orally
Arabic:	[ ] Speaks	[ ] Reads	[ ] Understands orally

Polish:	[ ] Speaks	[ ] Reads	[ ] Understands orally
Other (specify):	[ ] Speaks	[ ] Reads	[ ] Understands orally
Other specify:			

P. Communication

Client does not speak English as their primary language and has only a limited ability to read, speak, write OR understand English.:	( ) No	( ) Yes*
*Identify Primary Language:		
Client has been informed of their right to no cost interpretation?:	( ) No	( ) Yes
Communication plan identifying how language access needs will be met during service delivery:		
If professional interpretation services are declined, has client signed waiver of declination of interpreter services?:	( ) No	( ) Yes
Does the client have a hearing, speech, or visual impairment that requires accommodation for effective communication with service providers?:	( ) No	( ) Yes*
*Communication plan (i.e. use of 711/Relay, reading of printed material, ASL interpreter):		

Q. Living Arrangement

Living Arrangement:	( ) Alone	( ) Child (ren)	( ) Domestic Partner Only
	( ) Non-relative (s) in a community-based setting	( ) Non-relative (s) in a facility / institution or group setting	( ) Others Not Listed
	( ) Parent / Guardian	( ) With Domestic Partner & Others	( ) With Non-Relative (s)
	( ) With Relatives (excludes spouse)	( ) With Spouse	( ) With Spouse & Others

R. Contact Information

1. Emergency Contacts (For other contacts use the Contact Link on the side panel)

Primary: Secondary:

S. Elder Abuse/Neglect issues

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:

(Check if any of the following has occurred)

a. Do you feel unsafe at home with the people you have regular contact with?: ( ) No ( ) Yes

b. Has anyone forced you to sign document(s) that you did not want to sign - like checks or Power of Attorney?: ( ) No ( ) Yes

c. Has anyone scolded, yelled at, or threatened you in the last year?: ( ) No ( ) Yes

d. Has anyone taken things that belong to you without your consent?: ( ) No ( ) Yes

e. Does anyone force you to do things that you do not want to do?: ( ) No ( ) Yes

f. Has anyone tried to physically hurt or harm you in the last year?: ( ) No ( ) Yes

g. Have there been repeated times in the last year when the person you rely on to help you with household tasks, such as cleaning or shopping, or with personal assistance, such as bathing, has not done so?: ( ) No ( ) Yes

h. Has anyone living with you stopped contributing to household expenses like rent or food where they have previously agreed to do, and are capable of doing so now?: ( ) No ( ) Yes

T. Frail and/or Disabled

a. Is the client frail?: ( ) N/A ( ) No ( ) Yes

b. Is the client disabled?: ( ) N/A ( ) No ( ) Yes

U. Caregiving

Is client providing care for another individual?: ( ) No ( ) Yes

Relationship, nature of care, frequency:

V. Military Service

Have you or a member of your family served in the US military?: ( ) No ( ) Yes

Contacts List

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

Housing Status

A. Type of Housing

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

Other (specify):

B. Rent or Own

Rent or Own: ( ) Own ( ) Rent ( ) Other (Specify)

Other (specify):

Home Safety Checklist

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

Accumulated garbage: [ ]

Bad odors: [ ]

Carbon Monoxide detectors not present/not working or older than 7 years: [ ]

Client has no adequate/consistent heat and hot water: [ ]

Client has no/inadequate lighting: [ ]

Client has serious plumbing problems: [ ]

Client is at imminent risk of eviction/foreclosure:	[ ]	Client is at imminent risk of utility shut off:	[ ]
Dirty living areas:	[ ]	Doorway widths are inadequate:	[ ]
Exposed wiring/electric cords:	[ ]	Floors and stairways dirty and cluttered:	[ ]
Furnace not working:	[ ]	Insects/vermin:	[ ]
Loose scatter rugs present in one or more rooms:	[ ]	Mold/mildew signs present:	[ ]
No access to phone/emergency numbers:	[ ]	No grab bar in tub or shower:	[ ]
No handrails on the stairway:	[ ]	No lamp or light switch within easy reach of the bed:	[ ]
No lights in the bathroom or in the hallway:	[ ]	No locks on doors or not working:	[ ]
No rubber mats or non-slip decals in the tub or shower:	[ ]	Roof leaks:	[ ]
Smoke detectors not present/not working or older than 10 years:	[ ]	Smokers in household:	[ ]
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):		No housing issues:	[ ]

D. Air Conditioning

Does the client have a working air conditioner?:	( ) No	( ) Yes
If Yes, does the client use the air conditioner in the summer?:	( ) No	( ) Yes

E. Energy Checklist

Presence of drafts or cold spots:	[ ]		Use of space heaters:	[ ]
Heating fuel used:	[ ] Natural Gas	[ ] Oil	[ ] Electric	[ ] Propane
	[ ] Wood	[ ] Other		
Other Specify:			Estimate monthly energy bill:	

F. - H. Social Interaction

Does the client have family/ friends who visit at least weekly?:	( ) No	( ) Yes
Does the client speak with family/ friends at least several times weekly?:	( ) No	( ) Yes
Is the client able to participate in any outside social activities such as church, etc. at least weekly?:	( ) No	( ) Yes

I. Neighborhood Safety

Is neighborhood safety an issue?: ( ) No ( ) Yes

If Yes, describe:

Comments:

J. Pets

1. Does the client have pet(s): ( ) No ( ) Yes

A. Cats: [ ] # of:

B. Dogs: [ ] # of:

C. Other: [ ] # of:

Specify:

2. Are the pets a barrier to service provision?: ( ) No ( ) Yes

3. Is the pet a service animal?: ( ) No ( ) Yes

4. Have all pets had all required vaccinations including rabies shots this year (e.g. rabies, parvo, distemper, etc)?: ( ) No ( ) Yes

If No, explain:

5. In the event of an "emergency" are there plans for the care of the pet(s)?: ( ) No ( ) Yes

K. Self-Evacuation

Is the client able to self-evacuate their residence in the event of an emergency?: ( ) No ( ) Yes

Identify needs and evacuation plan (i.e. mobility impaired, lives on 3rd floor - elevator required, client on special needs registry):

L. Medical Treatment Emergency Accommodation

Is the client currently receiving ongoing medical treatments that require accommodation in the event of emergency or inclement weather? (i.e. dialysis, chemotherapy, methadone maintenance): ( ) No ( ) Yes

Treatment/Provider Contact Information:

M. Devices or Equipment Requiring Power

In the event of emergency or power outage does the client utilize devices or equipment that require electricity or an alterate power source? (i.e. oxygen, nebulizer, C-Pap machine, power chair that requires daily charging): ( ) No ( ) Yes

Identify equipment, service provider contact information

Equipment List

Provider Equipment	Provider Contact	Backup Plan	Release on File

Technology

1. Do you have any computer experience? Please mark only one response.: ( ) Yes: Beginner: e.g. turn on / off computer without help ( ) Yes: Intermediate: e.g. able to use email, browse the Internet ( ) Yes: Advanced: all of the above ( ) No

2. Do you have Internet connectivity?: ( ) Yes ( ) No

If yes, who is the provider?:

3. Do you have the following?

Modern Computer (5 years old or less): ( ) Yes ( ) No

iPad or Tablet: ( ) Yes ( ) No

Microphone: ( ) Yes ( ) No

Webcam: ( ) Yes ( ) No

Smart Phone: ( ) Yes ( ) No

4. Do you have a person to help you use your device or the Internet as needed?: ( ) Yes ( ) No

5. Comments:

Health Status

A. Health Care Providers

Primary Physician:

Clinic/HMO:

Hospital:

Primary Pharmacy:

Dentist or Hygienist:

Other:

B. Medical Insurance

Health Insurance Provider:

Health Insurance No.:

Secondary Health Insurance Provider:

Secondary Health Insurance No.:

Prescription Coverage Plan:

Prescription Coverage Plan No.:

Other Health Insurance Provider:

Other Health Insurance No.:

Has Medicaid: ( ) No ( ) Yes

Medicaid No.:

Has Medicare: ( ) No ( ) Yes

Medicare No.:

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

C. Health Care Plan Case Management

Does the client have an assigned case manager/care coordinator/ case worker through their health plan or other long term care plan?: ( ) No ( ) Yes

Case Manager/Care Coordinator Name and Contact Info:

D. Chronic Illness and/or Disability

* May indicate need for assessment by nutritionist

Does the person have a self-declared chronic illness and/or disability:

[ ] Alcoholism*	[ ] Alzheimer`s	[ ] Anorexia*	[ ] Arthritis
[ ] Asthma	[ ] Back Problems	[ ] Cancer*	[ ] Cellulitis
[ ] Chronic Diarrhea*	[ ] Chronic Obstructive Pulmonary Disease (COPD)	[ ] Chronic Pain	[ ] Colitis*
[ ] Colostomy*	[ ] Congestive Heart Failure*	[ ] Constipation*	[ ] Decubitus Ulcers*
[ ] Dehydration*	[ ] Dementia Related Illness	[ ] Dental Problems*	[ ] Developmental Disabilities
[ ] Diabetes (Type 1) *	[ ] Diabetes (Type 2) *	[ ] Dialysis*	[ ] 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	[ ] Mobility Impairment	[ ] Morbid Obesity*	[ ] Multiple Sclerosis
[ ] Osteoporosis	[ ] 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
[ ] Other (Specify)			

If Other, specify:

Assistive Devices

E. Assistive Devices

1. Does the person have an assistive device?: ( ) No ( ) Yes

If yes, check all that apply:

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

2. Does the person need an assistive device?: ( ) No ( ) Yes

If yes, specify device:

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

3. Does the person and/or caregiver need training on the use of an assistive device?: ( ) No ( ) Yes

If yes, describe the training needs:

Health Care Visits

F. Health Care Visits

Primary Medical Provider

Date of Last Visit (mm/dd/yyyy):

Number of Visits in last 12 Months:

Reason for Visit(s):

Dentist or Hygienist

Date of Last Visit (mm/dd/yyyy):

Number of Visits in last 12 Months:

Reason for Visit(s):

Hospitalization

Date of Last Visit (mm/dd/yyyy):

Number of Visits in last 12 Months:

Reason for Visit(s):

Clinic/Community Health Center

Date of Last Visit (mm/dd/yyyy):

Number of Visits in last 12 Months:

Reason for Visit(s):

Emergency Room

Date of Last Visit (mm/dd/yyyy):

Number of Visits in last 12 Months:

Reason for Visit(s):

Eye/Retinologist

Date of Last Visit (mm/dd/yyyy):

Number of Visits in last 12 Months:

Reason for Visit(s):

Audiologist

Date of Last Visit (mm/dd/yyyy):

Number of Visits in last 12 Months:

Reason for Visit(s):

G. PRI Score

Has a PRI been completed in the past 90 days?:	( ) No ( ) Yes
If Yes, describe the reason for completion:	
PRI Score:	
Completed by (Name and Affiliation):	
Date Completed (mm/dd/yyyy):	
Comments:	

H. UAS Assessment

Has a UAS Assessment been completed in the past 6 months?:	( ) No ( ) Yes
If Yes, describe the reason for completion:	
Completed by (Name and Affiliation):	
Date Completed (mm/dd/yyyy):	
Comments:	

Legal Information

I. Advanced Directives and Legal Information

Power of Attorney:	( ) No ( ) Yes
Power of Attorney Name:	
Power of Attorney Type:	( ) Durable ( ) Finance
Power of Attorney Name:	

Power of Attorney Type: ( ) Durable ( ) Finance

Legal Guardian: ( ) No ( ) Yes

Legal Guardian Name:

Legal Guardian Type: ( ) Article 81 ( ) Value 17-A

Legal Guardian Name:

Legal Guardian Type: ( ) Article 81 ( ) Value 17-A

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

Health Care Proxy:

MOLST: ( ) No ( ) Yes

Living Will: ( ) No ( ) Yes

Estate Will: ( ) No ( ) Yes

Would the client like more information in completing advanced directives?: ( ) No ( ) Yes

Legal Comments:

Nutrition

A. - C. General

Person's height - feet:

Height - Inches:

Height Source:

Person's weight:

Weight Source:

Body Mass Index:

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. Refrigeration

Are the person's refrigerator/ freezer and cooking facilities adequate?: ( ) No ( ) Yes

If No, describe:

E. Food Preparation

Is the person able to open containers/cartons and cut up food?: ( ) No ( ) Yes

If No, describe:

F. Emergency Food*

In the event of emergency or inclement weather, does the client maintain a shelf stable food supply that does not require refrigeration or heating?: ( ) No* ( ) Yes

*If no, case manager should be addressing in care plan (e.g. referral to food pantry, list of supplies, purchase of non-electric can opener)

G. Diet

Does the person have a physician prescribed modified therapeutic diet?: ( ) No ( ) Yes

If Yes, check all that apply:

[ ] Texture-Modified [ ] Calorie Controlled Diet [ ] Sodium Restricted [ ] Fat Restricted
[ ] High Calorie [ ] Renal [ ] Diabetic [ ] Liquid Nutritional Supplement
[ ] Other

If Other, specify:

If No, check all that apply:

[ ] Regular [ ] Special Diet [ ] Vegetarian [ ] Ethnic / Religious (specify)

If Ethnic/Religious, specify:

H. Food Allergies

Does the person have a physician-diagnosed food allergy?: ( ) No ( ) Yes

If Yes, describe:

I. Nutrition Supplements

Does the person use nutritional supplements?: ( ) No ( ) Yes

If Yes, specify who prescribed and the supplement:

J. Nutrition Screening (Use the NSI Link on the side panel)

K. Nutrition Problems

Does the client exhibit any of the following:

[ ] Anorexic Behaviors
[ ] Bulimic Behaviors
[ ] Compulsive Overeating
[ ] Decreased Appetite
[ ] Difficulty Chewing
[ ] Difficulty holding utensils and opening packages
[ ] Loose / Ill-fitting dentures
[ ] No appetite due to medication or medication side effect
[ ] No teeth at all and no dentures
[ ] Overweight
[ ] Underweight

L. Dental Hygiene

In the past 3 months, has the client been able to brush their teeth and/or clean their dentures regularly (at least once a day)?: ( ) No ( ) Yes

If No, select all that apply:

[ ] Cannot hold toothbrush / denture brush
[ ] Has trouble remembering / forgets
[ ] No toothbrush / denture brush
[ ] No toothpaste / denture cleaner
[ ] Other

M. Congregate Meals

Is the client unable to attend a congregate meal program because of an accident, illness, or frailty?: ( ) No ( ) Yes

N. Formal and Informal Supports - Meals

Does the client lack formal or informal supports who can regularly provide meals?: ( ) No ( ) Yes

O. - P. Home Delivered Meals

Is the client able to live safely at home if home delivered meal services are provided?: ( ) No ( ) Yes

The client is unable to prepare meals because (select all that apply): [ ] Lacks adequate cooking facilities [ ] Lacks knowledge or skills to prepare meals [ ] Unable to safely prepare meals [ ] Unable to shop or cook

Q. Spouse Less Than 60

Is there a non-senior spouse who is less than 60 years of age who would receive a HDM?: ( ) No ( ) Yes

R. Disabled Dependent

Is there a disabled dependent who is less than 60 years of age who would receive a HDM?: ( ) No ( ) Yes

S. Frozen Meal Eligibility Screening

1. Does the client have a working freezer, refrigerator, and equipment to heat their meal?: ( ) No ( ) Yes

2. Is there sufficient freezer capacity to store 3 or more packages of meals each measuring 9x7x2?: ( ) No ( ) Yes

3. Can the client safely operate/ manage a microwave oven, toaster oven, and/or oven?: ( ) No ( ) Yes

4. Can the client read and safely follow instructions about storage and re-heating meals?: ( ) No ( ) Yes

5. Can the client safely manage the receipt of multiple meals and cold packs from a deliverer at their front door and manage placement of those items in the refrigerator and freezer independently?: ( ) No ( ) Yes

6. Is the client able to handle a frozen meal? (Must answer the previous 5 questions): ( ) No ( ) Yes

Please indicate client's meal preference (applies to both weekday and weekend meals): [ ] Hot [ ] Chilled [ ] Frozen [ ] Regular [ ] Other

If Other, specify:

T. Existing Registered Dietician Referral

Have you been referred to a registered dietician? (If no, referral should be added to care plan.):	( ) No ( ) Yes

NSI

NSI Date *:		Author Name:	
Follow-up Date:			
Has an illness or conditions that made you change the kind and/or amount of food you eat.:	( ) No ( ) Yes		
Eats fewer than 2 meals per day.:	( ) No ( ) Yes		
Eats few fruits or vegetables, or milk products.:	( ) No ( ) Yes		
Has 3 or more drinks of beer, liquor, or wine almost every day.:	( ) No ( ) Yes		
Has tooth or mouth problems that make it hard for me to eat.:	( ) No ( ) Yes		
Does not always have enough money to buy the food I need.:	( ) No ( ) Yes		
Eat alone most of the time.:	( ) No ( ) Yes		
Takes 3 or more different prescribed or over-the-counter drugs a day.:	( ) No ( ) Yes		
Without wanting to, lost or gained 10 or more pounds in the last 6 months.:	( ) No ( ) Yes		
Not always physically able to shop, cook, and/or feed themselves.:	( ) No ( ) Yes		
Total NSI Score:		Conclusion: Based on the NSI score, this person's risk is:	
Comments:			

A score of 6 or more indicates "HIGH" nutritional risk; 3-5 indicates "MODERATE" nutritional risk; and 2 or less indicates "LOW" nutritional risk.

If a client is High Risk, take action! Make a case note and appropriate referral.

Psycho-Social Status

A. Psycho-Social Condition

Psycho-Social Status. 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	[ ] Self-neglect
[ ] Sleeping Problems	[ ] Suicidal Behavior	[ ] Suicidal Thoughts	[ ] Verbal Disruption
[ ] Worried or Anxious	[ ] Other (specify)		

If Other, specify:

B. Evidence of Substance Abuse Problems

Evidence of substance abuse problems?: ( ) No ( ) Yes

If Yes, describe:

C. CAGE (Use the CAGE Link on the side panel)

D. Behavioral Health

1. Problem behavior reported?: ( ) No ( ) Yes

If Yes, describe:

2. Diagnosed mental health problems?: ( ) No ( ) Yes

If Yes, describe:

3. History of mental health treatment?: ( ) No ( ) Yes

If Yes, describe:

E. Recent Deaths

In the past 12 months, the client experienced the death of (check all that apply):

[ ] Caregiver [ ] Child [ ] Other family or household member [ ] Spouse / domestic partner

[ ] Pet

F. Interest/Pleasure in Doing Things

Client reports little interest/ pleasure in doing things?: ( ) No ( ) Yes

G. Thoughts of Self Harm

Client has thoughts that they would be better off dead or of hurting themselves in some way?: ( ) No ( ) Yes

H. Mental Health Evaluation Needed

Does it appear that a mental health evaluation is needed? (If Yes, note Referral Plan in the Care Plan): ( ) No ( ) Yes

Psycho-Social Comments:

Loneliness Scale

In this 6-item scale, three statements are made about 'emotional loneliness' and three about 'social loneliness'.

Social loneliness (SL) occurs when someone is missing a wider social network and emotional loneliness (EL) is caused when you miss an "intimate relationship".

Loneliness Scale

Date (mm/dd/yyyy):

1. I experience a general sense of emptiness [EL] :	( ) Yes	( ) More or less	( ) No
2. I miss having people around me [EL]:	( ) Yes	( ) More or less	( ) No
3. I often feel rejected [EL]:	( ) Yes	( ) More or less	( ) No
4. There are plenty of people I can rely on when I have problems [SL]:	( ) Yes	( ) More or less	( ) No

5. There are many people I can trust completely [SL]:	( ) Yes ( ) More or less ( ) No
6. There are enough people I feel close to [SL]:	( ) Yes ( ) More or less ( ) No
Score:	
Comments:	

To score responses and interpret the results:

There are negatively (1-3) and positively (4-6) worded items. On the negatively worded items, the neutral and positive answers are scored as "1".

Therefore, on questions 1-3 score Yes=1, More or less=1, and No=0. On the positively worded items, the neutral and negative answers are scored as "1". Therefore, on questions 4-6, score Yes=0, More or less=1, and No=1.

This gives a possible range of scores from 0 to 6, which can be read as follows:

0 (Least lonely)

6 (Most lonely)

CAGE

The CAGE-AID (CAGE) is a brief screening tool used to identify issues with alcohol or drugs that may impact a person`s ability to function in their daily life.

Date (mm/dd/yyyy):

The CAGE Questionnaire (Check all that apply)

Have you ever felt you should cut down on your drinking or drug use?:	[ ]	Have people annoyed you by criticizing your drinking or drug use?:	[ ]
Have you ever felt bad or guilty about your drinking or drug use?:	[ ]	Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)?:	[ ]

Medications List

Name	Dose/Frequency	Reason Taken

Medication

B. Pharmacy

Primary Pharmacy Name:

C. Mail Order

Does client receive medication via mail order?: ( ) No ( ) Yes

D. Medication Problems

Does the person have any problems taking medications?: ( ) No ( ) Yes

E. Medication Allergies

Adverse reactions/allergies/ sensitivities?: ( ) No ( ) Yes

If Yes, describe:

F. Medication Cost

Cost of medication: ( ) No ( ) Yes

If Yes, describe:

G. Obtaining Medications

Obtaining medications: ( ) No ( ) Yes

If Yes, describe:

H. Other

Other (describe):

Comments:

Fall Risk Factors

Check all that Apply

Fall within past year: ( ) No ( ) Yes

Living Alone and > 85 years old: ( ) No ( ) Yes

Cognitive Impairment: ( ) No ( ) Yes

Cardiovascular Impairment: ( ) No ( ) Yes

Sensory Impairment: ( ) No ( ) Yes

Neuromuscular Changes: ( ) No ( ) Yes

Depression: ( ) No ( ) Yes

Urological Changes: ( ) No ( ) Yes

Stress: ( ) No ( ) Yes

Malnutrition: ( ) No ( ) Yes

PolyPharmacy:	( ) No	( ) Yes
Dehydration:	( ) No	( ) Yes
Substance Abuse/Use:	( ) No	( ) Yes
Acute Illness:	( ) No	( ) Yes
CVA History:	( ) No	( ) Yes
Home Hazards:	( ) No	( ) Yes
Housing Fall Risk Comments:		

IADLS History

Note: For the "Needs Met By" question, the answer should be chosen based on how the need is being met at the time of the Assessment.

A. Housework/Cleaning

Activity Status:	( ) Totally Able	( ) Requires intermittent supervision and / or minimal assistance	( ) Requires continual help with all or most of this task	( ) Person does not participate; another person performs all aspects of this task
Need Met By:	[ ] Assistive Devices	[ ] Formal Support	[ ] Informal Support	[ ] Unmet

Name of Person(s): Formal Support:

Comments:

B. Shopping

Activity Status:

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

Need Met By:

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

Name of Person(s):

Formal Support:

Comments:

C. Laundry

Activity Status:

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

Need Met By:

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

Name of Person(s):

Formal Support:

Comments:

D. Use Transportation

Activity Status:

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

Need Met By:

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

Name of Person(s):

Formal Support:

Comments:

E. Prepare and Cook Meals

Activity Status:

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

Need Met By:

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

Name of Person(s):

Formal Support:

Comments:

F. Handle Personal Business/Finances

Activity Status:

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

Need Met By:

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

Name of Person(s):

Formal Support:

Comments:

G. Use Telephone

Activity Status:

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

Need Met By:

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

Name of Person(s):

Formal Support:

Comments:

H. Self-Admin of Medication

Activity Status:

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

Need Met By:

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

Name of Person(s):

Formal Support:

Comments:

Conclusion

Are changes in IADL capacity expected in the next 6 months?:

( ) No | ( ) Yes

If yes, describe.:

Totals

Informal Support:

Formal Support:

Assistive Devices:

Unmet Needs:

ADLS History

Note: For the "Needs Met By" question, the answer should be chosen based on how the need is being met at the time of the Assessment.

A. Bathing

Activity Status:

( ) Requires no supervision or assistance. May use adaptive equipment.
( ) Requires intermittent checking and observing / minimal assistance at times
( ) Requires continual help.
( ) Person does not participate.

Need Met By:

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

Name of Person(s): Formal Support:

Comments:

B. Personal Hygiene

Activity Status:

( ) Requires no supervision or assistance.
( ) Requires intermittent supervision and / or minimal assistance.
( ) Requires continual help with all or most of personal grooming.
( ) Person does not participate; another person performs all aspects of personal hygiene

Need Met By:

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

Name of Person(s): Formal Support:

Comments:

C. Dressing

Activity Status:

( ) Needs no supervision or assistance.

( ) Needs intermittent supervision / minimal assistance at times.

( ) Requires continual help and / or physical assistance.

( ) Person does not participate, is dressed by another, or bed gown is generally worn due to condition of person.

Need Met By:

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

Name of Person(s):

Formal Support:

Comments:

D. Mobility

Activity Status:

( ) Walks with no supervision or assistance. May use adaptive equipment.

( ) Walks with intermittent supervision. May require human assistance at times.

( ) Walks with constant supervision and / or physical assistance.

( ) 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.

Need Met By:

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

Name of Person(s):

Formal Support:

Comments:

E. Transfer

Activity Status:

( ) Requires no supervision or assistance. May use adaptive equipment.

( ) Requires intermittent supervision. May require human assistance at times.

( ) Requires constant supervision and / or physical assistance.

( ) 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.

Need Met By:

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

Name of Person(s):

Formal Support:

Comments:

F. Toileting

Activity Status:

( ) Requires no supervision or physical assistance. May require special equipment, such as raised toilet or grab bars.

( ) Requires intermittent supervision and / or minimal assistance.

( ) Continent of bowel and bladder. Requires constant supervision and / or physical assistance.

( ) Incontinent of bowel and / or bladder.

Need Met By:

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

Name of Person(s):

Formal Support:

Comments:

G. Eating

Activity Status:

( ) Requires no supervision or assistance.

( ) Requires intermittent supervision and / or minimal physical assistance.

( ) Requires continual help and / or physical assistance.

( ) Person does not manually participate. Totally fed by hand, a tube or parental feeding for primary intake of food.

Need Met By:

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

Name of Person(s):

Formal Support:

Comments:

Conclusion

Are changes in ADL capacity expected in the next 6 months?: ( ) No ( ) Yes

If yes, describe.:

Totals

Informal Support:

Formal Support:

Assistive Devices:

Unmet Needs:

Services Receiving

Check all that Apply and Enter Provider Information

None Utilized: ( ) No ( ) Yes

Adult Day Health Care: ( ) No ( ) Yes

Provider Information:

Assisted Transportation: ( ) No ( ) Yes

Provider Information:

Caregiver Support: ( ) No ( ) Yes

Provider Information:	
Case Management:	( ) No ( ) Yes
Provider Information:	
Community-Based Food Program:	( ) No ( ) Yes
Provider Information:	
Consumer Directed In-home Services:	( ) No ( ) Yes
Provider Information:	
Congregate Meals:	( ) No ( ) Yes
Provider Information:	
Equipment/Supplies:	( ) No ( ) Yes
Provider Information:	
Friendly Visitor/Telephone Reassurance:	( ) No ( ) Yes
Provider Information:	
Health Promotion:	( ) No ( ) Yes
Provider Information:	
Health Insurance Counseling:	( ) No ( ) Yes
Provider Information:	
Home Health Aide:	( ) No ( ) Yes
Provider Information:	
Home Delivered Meals:	( ) No ( ) Yes
Provider Information:	
Hospice:	( ) No ( ) Yes
Provider Information:	
Housing Assistance:	( ) No ( ) Yes
Provider Information:	

Legal Services:	( ) No ( ) Yes
Provider Information:	
Mental Health Services:	( ) No ( ) Yes
Provider Information:	
Nutrition Counseling:	( ) No ( ) Yes
Provider Information:	
Occupational Therapy:	( ) No ( ) Yes
Provider Information:	
Outreach:	( ) No ( ) Yes
Provider Information:	
Personal Care Level 1 (Housekeeping/Chore):	( ) No ( ) Yes
Provider Information:	
Personal Care Level 2 (Homemaking/Personal Care):	( ) No ( ) Yes
Provider Information:	
Personal Emergency Response System (PERS):	( ) No ( ) Yes
Provider Information:	
Physical Therapy:	( ) No ( ) Yes
Provider Information:	
Protective Services:	( ) No ( ) Yes
Provider Information:	
Respite:	( ) No ( ) Yes
Provider Information:	
Respiratory Therapy:	( ) No ( ) Yes
Provider Information:	

Senior Center: ( ) No ( ) Yes

Provider Information:

Senior Companions: ( ) No ( ) Yes

Provider Information:

Services For The Blind: ( ) No ( ) Yes

Provider Information:

Shopping: ( ) No ( ) Yes

Provider Information:

Skilled Nursing: ( ) No ( ) Yes

Provider Information:

Social Adult Day Care: ( ) No ( ) Yes

Provider Information:

Speech Therapy: ( ) No ( ) Yes

Provider Information:

Transportation: ( ) No ( ) Yes

Provider Information:

Other: ( ) No ( ) Yes

Provider Information: If Other, specify:

Informal Support Status

A. Informal Supports

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

1. Primary Informal Support

Primary Informal Support:

Involvement (Type of help/ frequency):

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

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 [ ] Overwhelmed

1. d. Is the informal support received: ( ) Adequate ( ) Inadequate ( ) Temporarily unavailable

1. e. Would this informal support be considered the caregiver? (Definition of caregiver can be found in the COMPASS instructions.): ( ) No ( ) Yes

1. f. Does the caregiver identify the need for respite?: ( ) No ( ) Yes

If Yes, when?:

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

1. g. 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. h. Would the caregiver like to receive information about other caregiver services?: ( ) No ( ) Yes

2. Secondary Informal Support

Secondary Informal Support:

Involvement (Type of help/ frequency):

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

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 inolvement? (Check all that apply):
[ ] Job [ ] Finances [ ] Family [ ] Responsibilities
[ ] Physical Burden [ ] Transportation [ ] Emotional Burden [ ] Health Problems
[ ] Reliability [ ] Living Distance [ ] Overwhelmed

2. d. Is the informal support received:
( ) Adequate ( ) Inadequate ( ) Temporarily unavailable

2. e. Would this informal support be considered the caregiver? (Definition of caregiver can be found in the COMPASS instructions.):
( ) No ( ) Yes

2. f. Does the caregiver identify the need for respite?:
( ) No ( ) Yes

If Yes, when?:
[ ] Morning [ ] Afternoon [ ] Evening [ ] Overnight
[ ] Weekend [ ] Needs relief and would take it any time [ ] Day & Evening [ ] Other

2. g. 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. h. Would the caregiver like to receive information about other caregiver services?:
( ) No ( ) Yes

B. Caregiver Supports

Can other informal support(s) provider temporary care to relieve the caregiver(s)?:
( ) No ( ) Yes

If yes, describe.:

C. Other Informal Supports

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:

Monthly Income

A. Monthly Income

Poverty Level: ( ) <100 ( ) 100-124 ( ) 125-149 ( ) 150-184 ( ) 185+ ( ) Refused to Answer ( ) Unsure

B. Number in Household

Number of people in household:

Low Income Minority: ( ) N/A ( ) No ( ) Yes

SOURCES OF INCOME

Source	A. Individual Being Assessed	B. Person's Spouse	C. Other Family/ Household Income	D. Total Family/ Household Income (Total Month / Total Year)
Social Security (net)				
Supplemental Security Income: (SSI)				
Personal Retirement Income				
Interest				
Dividends				
Salary/Wages				
Other				
Total Monthly Income				
Total Annual Income				

*Note only columns A + B are used for EISEP cost share.

C. Veteran Status

Is client a veteran?: ( ) No ( ) Yes

D. Financial Information Refused

Check if person will provide no financial information: [ ]

If checked, describe:

E. - F. Voter Information

Is client registered to vote?: ( ) No ( ) Yes

If No, was client offered a voter registration application?: ( ) No ( ) Yes

Benefits/Entitlements

Income Related Benefits

Social Security:

( ) 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
( ) E. Denied
( ) F. Application Pending
( ) G. Does Not Need
( ) H. Not Applicable
( ) I. Not Eligible

Comments:

SSI (Persons receiving SSI are categorically eligible for Medicaid and should have a Medicaid card.):

( ) 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
( ) E. Denied
( ) F. Application Pending
( ) G. Does Not Need
( ) H. Not Applicable
( ) I. Not Eligible

Comments:

Railroad Retirement:

( ) 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
( ) E. Denied
( ) F. Application Pending
( ) G. Does Not Need
( ) H. Not Applicable
( ) I. Not Eligible

Comments:

SSD:

( ) 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
( ) E. Denied
( ) F. Application Pending
( ) G. Does Not Need
( ) H. Not Applicable
( ) I. Not Eligible

Comments:

Veteran's Benefits:

( ) 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
( ) E. Denied
( ) F. Application Pending
( ) G. Does Not Need
( ) H. Not Applicable
( ) I. Not Eligible

Specify:

Comments:

Other:

( ) 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
( ) E. Denied
( ) F. Application Pending
( ) G. Does Not Need
( ) H. Not Applicable
( ) I. Not Eligible

Specify:

Comments:

Entitlements

Medicaid Number:

( ) 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
( ) E. Denied
( ) F. Application Pending
( ) G. Does Not Need
( ) H. Not Applicable
( ) I. Not Eligible

Comments:

Food Stamps (SNAP):

( ) 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
( ) E. Denied
( ) F. Application Pending
( ) G. Does Not Need
( ) H. Not Applicable
( ) I. Not Eligible

Comments:

Public Assistance:

( ) 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
( ) E. Denied
( ) F. Application Pending
( ) G. Does Not Need
( ) H. Not Applicable
( ) I. Not Eligible

Comments:

Other:

( ) 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
( ) E. Denied
( ) F. Application Pending
( ) G. Does Not Need
( ) H. Not Applicable
( ) I. Not Eligible

Specify:

Comments:

Health Related Benefits

Medicare Number:

( ) 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
( ) E. Denied
( ) F. Application Pending
( ) G. Does Not Need
( ) H. Not Applicable
( ) I. Not Eligible

Comments:

QMB:

( ) 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
( ) E. Denied
( ) F. Application Pending
( ) G. Does Not Need
( ) H. Not Applicable
( ) I. Not Eligible

Comments:

SLMB/QI:

( ) 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
( ) E. Denied
( ) F. Application Pending
( ) G. Does Not Need
( ) H. Not Applicable
( ) I. Not Eligible

Comments:

EPIC:

( ) 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
( ) E. Denied
( ) F. Application Pending
( ) G. Does Not Need
( ) H. Not Applicable
( ) I. Not Eligible

Comments:

Low Income Subsidy (LIS):

( ) 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
( ) E. Denied
( ) F. Application Pending
( ) G. Does Not Need
( ) H. Not Applicable
( ) I. Not Eligible

Comments:

Medicare Part D (Drug Coverage):

( ) 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
( ) E. Denied
( ) F. Application Pending
( ) G. Does Not Need
( ) H. Not Applicable
( ) I. Not Eligible

Comments:

Medigap Insurance/Medicare Advantage (Specify):

( ) 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
( ) E. Denied
( ) F. Application Pending
( ) G. Does Not Need
( ) H. Not Applicable
( ) I. Not Eligible

Specify:

Comments:

Long Term Care Insurance:

( ) 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
( ) E. Denied
( ) F. Application Pending
( ) G. Does Not Need
( ) H. Not Applicable
( ) I. Not Eligible

Specify:

Comments:

Other Health Insurance:

( ) 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
( ) E. Denied
( ) F. Application Pending
( ) G. Does Not Need
( ) H. Not Applicable
( ) I. Not Eligible

Specify:

Comments:

Housing Related Benefits

Senior Citizens Exemption (Local option income based):

( ) 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
( ) E. Denied
( ) F. Application Pending
( ) G. Does Not Need
( ) H. Not Applicable
( ) I. Not Eligible

Comments:

SCRIE:

( ) 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
( ) E. Denied
( ) F. Application Pending
( ) G. Does Not Need
( ) H. Not Applicable
( ) I. Not Eligible

Comments:

Section 8:

( ) 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
( ) E. Denied
( ) F. Application Pending
( ) G. Does Not Need
( ) H. Not Applicable
( ) I. Not Eligible

Comments:

IT214:

( ) 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
( ) E. Denied
( ) F. Application Pending
( ) G. Does Not Need
( ) H. Not Applicable
( ) I. Not Eligible

Comments:

Veteran Tax Exemption:

( ) 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
( ) E. Denied
( ) F. Application Pending
( ) G. Does Not Need
( ) H. Not Applicable
( ) I. Not Eligible

Comments:

Reverse Mortgage:

( ) 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
( ) E. Denied
( ) F. Application Pending
( ) G. Does Not Need
( ) H. Not Applicable
( ) I. Not Eligible

Comments:

Real Property Tax Exemption (Enhanced STAR):

( ) 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
( ) E. Denied
( ) F. Application Pending
( ) G. Does Not Need
( ) H. Not Applicable
( ) I. Not Eligible

Comments:

Real Property Tax Exemption (Basic STAR):

( ) 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
( ) E. Denied
( ) F. Application Pending
( ) G. Does Not Need
( ) H. Not Applicable
( ) I. Not Eligible

Comments:

HEAP:

( ) 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
( ) E. Denied
( ) F. Application Pending
( ) G. Does Not Need
( ) H. Not Applicable
( ) I. Not Eligible

Comments:

Other:

( ) 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
( ) E. Denied	( ) F. Application Pending	( ) G. Does Not Need	( ) H. Not Applicable
( ) I. Not Eligible			

Specify:

Comments: