

15. Residential/Living Status at Time of Assessment (i.e., location of assessment)

a. 1-Private home/apartment/rented room
 2-Assisted living facility
 3-Home plus/group home
 4-Long-term care facility (nursing homes, including skilled)
 5-Hospice facility/palliative care unit
 6-Acute care hospital/unit
 7-Rehabilitation hospital/unit
 8-TBI rehabilitation facility (TBIRF)
 9-Psychiatric residential treatment facility
 10-Nursing facility-mental health
 11-Psychiatric hospital/unit
 12-Intermediate care facility for individuals with ID (ICF-IID)
 13-Correctional facility
 14-Homeless (with or without shelter)
 15-Other: _____

b. Is this residence permanent? Yes No

c. If not permanent, identify permanent residence (insert number from above)

16. Living Arrangement

a. Alone
 With spouse/partner only
 With spouse/partner and other(s)
 With child (but not with spouse/partner)
 With parent(s) or guardian(s)
 With sibling(s)
 With other relative(s)
 With nonrelative(s)
 Not applicable (e.g., institutional setting)

b. As compared to 90 DAYS AGO (or since last assessment), person now lives with someone new—e.g., moved in with another person, other moved in)
 Yes No

c. Person feels that s/he would be better off living elsewhere
 No
 Yes, other community residences
 Yes, institution

d. Relative/caregiver feels that the person would be better off living elsewhere
 No
 Yes, other community residences
 Yes, institution
 Not applicable or unknown

17. Time Since Last Hospital Stay Code for most recent instance in LAST 90 DAYS

a. No hospitalization within 90 days
 31-90 days ago
 15-30 days ago
 8-14 days ago
 In the last 7 days
 Now in the hospital

b. Number of Hospitalizations in the Last 90 days: _____

18. Residential History Over Last 5 YEARS Code for all institutional settings person lived in during 5 YEARS prior to date case opened (item 13) (Check all that apply)

Long-term care facility—e.g., nursing home
 Board and care home, assisted living
 Psychiatric residential treatment facility
 Psychiatric hospital or unit
 Intermediate care facility for individuals with ID (ICF-IID)
 TBI Rehabilitation Facility (TBIRF)
 Correctional facility
 Unknown
 None

19. Ethnicity and Race (check all that apply)

Ethnicity
 Hispanic or Latino

Race
 American Indian or Alaska Native
 Asian
 Black or African
 American Native Hawaiian or other Pacific Islander
 White
 Other (check only if not listed above)

20. Primary Language

a. English Chinese/Cantonese
 Spanish Hindi
 French Urdu
 German Lao
 Russian Sign Language
 Filipino/Tagalog Braille
 Vietnamese Non-Verbal
 Other

b. Interpreter used
 Yes No
 If yes:
 Professional
 Family/friend

21. Disaster Risk (non-crisis) (check all that apply)

Electric Cognitive/mental health Issues
 Physical impairment No informal support
 Medication assistance None

22. Person's Expressed Goals of Care (Enter major goals in large box below, enter primary goal in small boxes at bottom)

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Comments:

A more accurate assessment often requires conversations with caregivers or others who have direct knowledge of the person's needs and strengths over time.

SECTION II: PASRR	
Preadmission Screening and Resident Review (PASRR) Level 1	
Note: Complete for CARE consumers only (e.g., NF admission/application)	
1. Has anyone suggested the person should move to a nursing facility (NF)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Has the person been diagnosed as having a Serious Mental Illness (SMI) or indications of a disorder classified in DSM-IV/V; examples include: <ul style="list-style-type: none"> • A schizophrenic, mood, paranoid, panic or other serious anxiety disorder • A somatoform disorder • A personality disorder • Another psychotic disorder • Another mental disorder that may lead to a chronic disability (Check <i>one</i>) <input type="checkbox"/> Yes, SMI diagnosis present. Specify: _____ <input type="checkbox"/> Indications of SMI, but no diagnosis present (complete items 9a-k in Section II : Mood and Behavior) <input type="checkbox"/> No/none	
3. a. What psychiatric treatment has the person received in the past 2 years? (check <i>all</i> that apply) <ul style="list-style-type: none"> <input type="checkbox"/> 2 partial hospitalizations <input type="checkbox"/> 2 inpatient hospitalizations <input type="checkbox"/> 1 Inpatient & 1 partial hospitalization <input type="checkbox"/> Support Services (e.g. increase in case management) <input type="checkbox"/> Intervention (e.g., police, housing, APS involvement) <input type="checkbox"/> None b. For individuals who have a SMI diagnosis and treatment history please record that information: _____	
4. Area of impairment due to serious mental illness? (Check <i>all</i> that apply) <ul style="list-style-type: none"> <input type="checkbox"/> Interpersonal functioning <input type="checkbox"/> Concentration/persistence/pace <input type="checkbox"/> Adaptation to change <input type="checkbox"/> None 	
5. a. Has the person been diagnosed with one of the following conditions prior to age 18 for Intellectual/Developmental Disability (IDD), or age 22 for related condition, and the condition is likely to continue indefinitely? <ul style="list-style-type: none"> <input type="checkbox"/> Intellectual/Developmental Disability (IQ, if known (____)) <input type="checkbox"/> Related Condition (record below) <input type="checkbox"/> Indications of I/DD or a related condition (Explain below) <input type="checkbox"/> None (Skip to instruction at bottom of this column) b. For those individuals who have an I/DD or related condition, or indications thereof, please record diagnosis or indications: _____ _____	
c. For those individuals who have an I/DD or related condition, or indications thereof, please record age of onset: _____	
d. For those individuals who have an I/DD or related condition, or indications thereof, please record services received: _____	
e. For those individuals who have an I/DD or related condition, or indications thereof, please make a referral or record if a recent referral was already made: <input type="checkbox"/> Yes <input type="checkbox"/> No Referral Date: _____ Agency referred to: _____	
Instruction: If the answers were no/none to ALL questions 2 thru 5, skip to question 8. If a SMI or IDD diagnosis, indications, or treatment history is present (e.g. items 2-5), questions 6 & 7 are also required.	
6. a. Does the person have a primary diagnosis of dementia or Alzheimer's disease? <input type="checkbox"/> Yes <input type="checkbox"/> No, the individual has dementia but it is not primary (proceed to item 7 in section II) <input type="checkbox"/> No (proceed to item 7 in section II)	b. If yes to 6a, is corroborative testing or other information available to verify the presence or progression of the dementia? <input type="checkbox"/> No <input type="checkbox"/> Yes, <i>check all that apply:</i> <input type="checkbox"/> Dementia work up <input type="checkbox"/> Comprehensive Mental Status Exam <input type="checkbox"/> Other, specify _____
c. If yes to 6a, please indicate the following: <input type="checkbox"/> Documentation is attached <input type="checkbox"/> Instructions for submitting documentation were provided	
7. a. Does the person have a documented terminal or severe illness? <input type="checkbox"/> No <input type="checkbox"/> Yes, person meets the following criteria: <input type="checkbox"/> Terminal Illness: <ul style="list-style-type: none"> • Prognosis of life expectancy of 6 months or less • There is no current risk to self or others and behaviors/symptoms are stable <input type="checkbox"/> Severe, deteriorating condition: <ul style="list-style-type: none"> • Coma, ventilator dependent, brain-stem functioning, progressed ALS, progressed Huntington's, etc., so severe that the individual would be unable to participate in a program of specialized care associated with his/her SMI and/or I/DD • There is no current risk to self or others and behaviors/symptoms are stable 	
b. If yes to 6a, please indicate the following: <input type="checkbox"/> Documentation is attached <input type="checkbox"/> Instructions for submitting documentation were provided	
8.a. Does the person have a substance related disorder? (check <i>one</i>) <input type="checkbox"/> Yes, diagnosis present. Specify: _____ <input type="checkbox"/> Indications of substance use disorder. Explain: _____ _____ <input type="checkbox"/> No/none (skip to question 4a in this section)	
b. Is NF need associated with substance use disorder <input type="checkbox"/> Yes <input type="checkbox"/> No c. When did the most recent substance abuse occur? <input type="checkbox"/> 1-30 days <input type="checkbox"/> 31-90 days <input type="checkbox"/> Unknown	
9. Is NF stay Anticipated less than 30 days (e.g., rehab or respite)? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, attach Physicians order if available)	
10. Referred for PASRR Level II Assessment? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Consult training and instruction manual for determining if Level II referral needed, based on the information above.</i>	
11. Individual Choice for LTSS <input type="checkbox"/> Home without services <input type="checkbox"/> Home with services <input type="checkbox"/> ALF/Residential/Boarding Care <input type="checkbox"/> Other: _____ <input type="checkbox"/> Nursing Facility: (Name) _____ Street: _____ City: _____ State _____ Zip _____ Phone _____	
PASRR comments: _____ _____	
END OF PASRR	

SECTION III: FUNCTIONAL ASSESSMENT	
COGNITION	
1. COGNITIVE SKILLS FOR DAILY DECISION MAKING <i>Making decisions regarding tasks of daily life—e.g., when to get up or have meals, which clothes to wear or activities to do</i>	
<input type="checkbox"/> Independent —Decisions consistent, reasonable, and safe <input type="checkbox"/> Modified independence —Some difficulty in new situations only <input type="checkbox"/> Minimally impaired —In specific recurring situations, decisions become poor or unsafe; cues / supervision necessary at those times <input type="checkbox"/> Moderately impaired —Decisions consistently poor or unsafe; cues / supervision required at all times <input type="checkbox"/> Severely impaired —Never or rarely makes decisions <input type="checkbox"/> No discernable consciousness, coma (Skip to Functional Status)	
2. MEMORY / RECALL ABILITY <i>Code for recall of what was learned or known.</i>	
a. Short-term memory OK —Seems / appears to recall after 5 minutes (e.g. 3-word recall) <input type="checkbox"/> Yes, Memory OK <input type="checkbox"/> Memory Problem	
b. Procedural memory OK —Can perform all or almost all steps in a multitask sequence without cues <input type="checkbox"/> Yes, Memory OK <input type="checkbox"/> Memory Problem	
c. Situational memory OK —Both: recognizes caregivers' names / faces frequently encountered AND knows location of places regularly visited (bedroom, dining room, activity room, therapy room) <input type="checkbox"/> Yes, Memory OK <input type="checkbox"/> Memory Problem	
3. PERIODIC DISORDERED THINKING OR AWARENESS <i>[Note: Accurate assessment requires conversations with staff, family, or others who have direct knowledge of the person's behavior over this time]</i>	
a. Easily distracted —e.g., episodes of difficulty paying attention; gets sidetracked <input type="checkbox"/> Behavior not present <input type="checkbox"/> Behavior present, consistent with usual functioning <input type="checkbox"/> Behavior present, appears different from usual functioning (e.g., new onset or worsening; different from a few weeks ago)	
b. Episodes of disorganized speech —e.g., speech is nonsensical, irrelevant, or rambling from subject to subject; loses train of thought <input type="checkbox"/> Behavior not present <input type="checkbox"/> Behavior present, consistent with usual functioning <input type="checkbox"/> Behavior present, appears different from usual functioning (e.g., new onset or worsening; different from a few weeks ago)	
c. Mental function varies over the course of the day —e.g., sometimes better, sometimes worse <input type="checkbox"/> Behavior not present <input type="checkbox"/> Behavior present, consistent with usual functioning <input type="checkbox"/> Behavior present, appears different from usual functioning (e.g., new onset or worsening; different from a few weeks ago)	
4. TBI COGNITION (Complete for TBI consumers only)	
a. Fund of information <i>Problems remembering information learned in school or on the job; difficulty remembering information about self and family from years ago.</i> <input type="checkbox"/> None/no problem <input type="checkbox"/> Mild problem but does not interfere with activities; may use assistive device or medication <input type="checkbox"/> Mild problem; interferes with activities 5-24% of the time <input type="checkbox"/> Moderate problem; interferes with activities 25-74% of the time. <input type="checkbox"/> Severe problem; interferes with activities more than 75% of the time	

b. Impaired self awareness *Lack of recognition of personal limitations and disabilities, and how they interfere with everyday activities and work or school.*

- None/no problem**
 Mild problem but does not interfere with activities; may use assistive device or medication
 Mild problem; interferes with activities 5-24% of the time
 Moderate problem; interferes with activities 25-74% of the time.
 Severe problem; interferes with activities more than 75% of the time

c. Safety judgment *Includes orientation to situation, awareness of deficits and their implications, ability to plan ahead, ability to understand the nature of situations involving potential danger and to identify risks involved, freedom from impulsivity, ability to remember safety related information, ability to protect self against victimization by others, and ability to respond appropriately if danger arises.*

- None/no problem**
 Mild problem but does not interfere with activities; may use assistive device or medication
 Mild problem; interferes with activities 5-24% of the time
 Moderate problem; interferes with activities 25-74% of the time.
 Severe problem; interferes with activities more than 75% of the time

Who was the primary informant for information on Cognition? (check one) Consumer Family/Friend
 Legal Guardian/DPOA Provider

Which additional informants provided information on Cognition? (check all that apply) Consumer Family/Friend
 Legal Guardian/DPOA Provider

COMMUNICATION AND VISION

5. MAKING SELF UNDERSTOOD (Expression) (TBI only) *Expressing information content—both verbal and nonverbal*

Understood—Expresses ideas without difficulty
 Usually understood—Difficulty finding words or finishing thoughts BUT if given time, little or no prompting required
 Often understood—Difficulty finding words or finishing thoughts AND prompting usually required
 Sometimes understood—Ability is limited to making concrete requests
 Rarely or never understood

6. ABILITY TO UNDERSTAND OTHERS (Comprehension) (TBI only) *Understanding verbal information content (however able; with hearing appliance normally used)*

- Understands**—Clear comprehension
 Usually understands—Misses some part/intent of message BUT comprehends most conversation
 Often understands—Misses some part/intent of message BUT with repetition or explanation can often comprehend conversation
 Sometimes understands—Responds adequately to simple, direct communication only
 Rarely or never understands

<p>7. HEARING Ability to hear (with hearing appliance normally used)</p> <p><input type="checkbox"/> Adequate—No difficulty in normal conversation, social interaction, listening to TV</p> <p><input type="checkbox"/> Minimal difficulty—Difficulty in some environments (e.g., when person speaks softly or is more than 6 feet [2 meters] away)</p> <p><input type="checkbox"/> Moderate difficulty—Problem hearing normal conversation, requires quiet setting to hear well</p> <p><input type="checkbox"/> Severe difficulty—Difficulty in all situations (e.g., speaker has to talk loudly or speak very slowly; or person reports that all speech is mumbled)</p> <p><input type="checkbox"/> No hearing</p>	<p>i. Withdrawal from activities of interest—e.g., long-standing activities, being with family / friends (complete for TBI & CARE)</p> <p><input type="checkbox"/> Not Present <input type="checkbox"/> Present but not exhibited in last 3 days</p> <p><input type="checkbox"/> Exhibited on 1-2 of last 3 days <input type="checkbox"/> Exhibited daily in last 3 days</p>
<p>8. VISION Ability to see in adequate light (with glasses or with other visual appliance normally used)</p> <p><input type="checkbox"/> Adequate—Sees fine detail, including regular print in newspaper/books</p> <p><input type="checkbox"/> Minimal difficulty—Sees large print, but not regular print in newspaper/books</p> <p><input type="checkbox"/> Moderate difficulty—Limited vision; not able to see newspaper headlines, but can identify objects</p> <p><input type="checkbox"/> Severe difficulty—Object identification in question, but eyes appear to follow objects; sees only light, colors, shapes</p> <p><input type="checkbox"/> No vision</p>	<p>j. Reduced social interactions (complete for TBI & CARE)</p> <p><input type="checkbox"/> Not Present <input type="checkbox"/> Present but not exhibited in last 3 days</p> <p><input type="checkbox"/> Exhibited on 1-2 of last 3 days <input type="checkbox"/> Exhibited daily in last 3 days</p>
MOOD AND BEHAVIOR	
<p>9. INDICATORS OF POSSIBLE DEPRESSED, ANXIOUS, OR SAD MOOD (CARE consumers receive all items; TBI consumers only receive items I and J; not applicable for FE or PD consumers.) Code for indicators observed in last 3 days, irrespective of the assumed cause [Note: Whenever possible, ask person].</p>	<p>k. Expressions, including nonverbal, of a lack of pleasure in life (anhedonia)—e.g., “I don’t enjoy anything anymore</p> <p><input type="checkbox"/> Not Present <input type="checkbox"/> Present but not exhibited in last 3 days</p> <p><input type="checkbox"/> Exhibited on 1-2 of last 3 days <input type="checkbox"/> Exhibited daily in last 3 days</p>
<p>a. Made negative statements—e.g., “Nothing matters,” “Would rather be dead,” “What’s the use”; “Regret having lived so long”; “Let me die”</p> <p><input type="checkbox"/> Not Present <input type="checkbox"/> Present but not exhibited in last 3 days</p> <p><input type="checkbox"/> Exhibited on 1-2 of last 3 days <input type="checkbox"/> Exhibited daily in last 3 days</p>	<p>10. BEHAVIOR SYMPTOMS Code for indicators observed, irrespective of the assumed cause</p>
<p>b. Persistent anger with self or others—e.g., easily annoyed, anger at care received</p> <p><input type="checkbox"/> Not Present <input type="checkbox"/> Present but not exhibited in last 3 days</p> <p><input type="checkbox"/> Exhibited on 1-2 of last 3 days <input type="checkbox"/> Exhibited daily in last 3 days</p>	<p>a. Wandering—Moved with no rational purpose, seemingly oblivious to needs or safety</p> <p><input type="checkbox"/> Not present <input type="checkbox"/> Present but not exhibited in last 3 days</p> <p><input type="checkbox"/> Exhibited on 1-2 of last 3 days <input type="checkbox"/> Exhibited daily in last 3 days</p>
<p>c. Expression, including nonverbal, of what appear to be unrealistic fears—e.g., fear of being abandoned, being left alone, being with others; intense fear of specific objects or situations</p> <p><input type="checkbox"/> Not Present <input type="checkbox"/> Present but not exhibited in last 3 days</p> <p><input type="checkbox"/> Exhibited on 1-2 of last 3 days <input type="checkbox"/> Exhibited daily in last 3 days</p>	<p>b. Verbal abuse—e.g., others were threatened, screamed at, cursed at</p> <p><input type="checkbox"/> Not present <input type="checkbox"/> Present but not exhibited in last 3 days</p> <p><input type="checkbox"/> Exhibited on 1-2 of last 3 days <input type="checkbox"/> Exhibited daily in last 3 days</p>
<p>d. Repetitive health complaints—e.g., persistently seeks medical attention, incessant concern with body functions</p> <p><input type="checkbox"/> Not Present <input type="checkbox"/> Present but not exhibited in last 3 days</p> <p><input type="checkbox"/> Exhibited on 1-2 of last 3 days <input type="checkbox"/> Exhibited daily in last 3 days</p>	<p>c. Physical abuse—e.g., others were hit, shoved, scratched, sexually abused</p> <p><input type="checkbox"/> Not present <input type="checkbox"/> Present but not exhibited in last 3 days</p> <p><input type="checkbox"/> Exhibited on 1-2 of last 3 days <input type="checkbox"/> Exhibited daily in last 3 days</p>
<p>e. Repetitive anxious complaints/concerns (non-health related)—e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationships</p> <p><input type="checkbox"/> Not Present <input type="checkbox"/> Present but not exhibited in last 3 days</p> <p><input type="checkbox"/> Exhibited on 1-2 of last 3 days <input type="checkbox"/> Exhibited daily in last 3 days</p>	<p>d. Socially inappropriate or disruptive behavior—e.g., made disruptive sounds or noises, screamed out, smeared or threw food or feces, hoarded, rummaged through other’s belongings</p> <p><input type="checkbox"/> Not present <input type="checkbox"/> Present but not exhibited in last 3 days</p> <p><input type="checkbox"/> Exhibited on 1-2 of last 3 days <input type="checkbox"/> Exhibited daily in last 3 days</p>
<p>f. Sad, pained, or worried facial expressions—e.g., furrowed brow, constant frowning</p> <p><input type="checkbox"/> Not Present <input type="checkbox"/> Present but not exhibited in last 3 days</p> <p><input type="checkbox"/> Exhibited on 1-2 of last 3 days <input type="checkbox"/> Exhibited daily in last 3 days</p>	<p>e. Inappropriate public behavior or public disrobing</p> <p><input type="checkbox"/> Not present <input type="checkbox"/> Present but not exhibited in last 3 days</p> <p><input type="checkbox"/> Exhibited on 1-2 of last 3 days <input type="checkbox"/> Exhibited daily in last 3 days</p>
<p>g. Crying, tearfulness</p> <p><input type="checkbox"/> Not Present <input type="checkbox"/> Present but not exhibited in last 3 days</p> <p><input type="checkbox"/> Exhibited on 1-2 of last 3 days <input type="checkbox"/> Exhibited daily in last 3 days</p>	<p>f. Resists care—e.g., taking medications/injections, ADL assistance, eating</p> <p><input type="checkbox"/> Not present <input type="checkbox"/> Present but not exhibited in last 3 days</p> <p><input type="checkbox"/> Exhibited on 1-2 of last 3 days <input type="checkbox"/> Exhibited daily in last 3 days</p>
<p>h. Recurrent statements that something terrible is about to happen—e.g., believes he/she is about to die, have a heart attack</p> <p><input type="checkbox"/> Not Present <input type="checkbox"/> Present but not exhibited in last 3 days</p> <p><input type="checkbox"/> Exhibited on 1-2 of last 3 days <input type="checkbox"/> Exhibited daily in last 3 days</p>	<p>g. Self-injurious behavior—e.g., banging head on wall, pinching, biting, scratching, hitting or punching self, pulling own hair.</p> <p><input type="checkbox"/> Not present <input type="checkbox"/> Present but not exhibited in last 3 days</p> <p><input type="checkbox"/> Exhibited on 1-2 of last 3 days <input type="checkbox"/> Exhibited daily in last 3 days</p>
<p>Who was the primary informant for information on Mood and Behavior? (check one) <input type="checkbox"/> Consumer <input type="checkbox"/> Family/Friend <input type="checkbox"/> Legal Guardian/DPOA <input type="checkbox"/> Provider</p>	
<p>Which additional informants provided information on Mood and Behavior? (check all that apply) <input type="checkbox"/> Consumer <input type="checkbox"/> Family/Friend <input type="checkbox"/> Legal Guardian/DPOA <input type="checkbox"/> Provider</p>	
PSYCHOSOCIAL WELL-BEING	
<p>11. CURRENT ABUSE/NEGLECT/EXPLOITATION RISK: <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Self-neglect <input type="checkbox"/> Abuse <input type="checkbox"/> Neglect <input type="checkbox"/> Exploitation</p>	
<p>Comments:</p>	

FUNCTIONAL STATUS			
12. IADL SELF-PERFORMANCE AND CAPACITY			
<ul style="list-style-type: none"> • Code for PERFORMANCE (P) in routine activities around the home or in the community during the LAST 3 DAYS. • Code for CAPACITY (C) based on presumed ability to carry out activity as independently as possible. This will require "speculation" by the assessor. <p>Independent—No help, setup, or supervision Setup help only Supervision—Oversight / cuing Limited assistance—Help on some occasions Extensive assistance—Help throughout task, but performs 50% or more of task on own Maximal assistance—Help throughout task, but performs less than 50% of task on own Total dependence—Full performance by others during entire period Activity did not occur—During entire period [DO NOT USE THIS CODE IN SCORING CAPACITY]</p>			
a. Meal preparation —How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils)			
IADL PERFORMANCE	<input type="checkbox"/> Independent <input type="checkbox"/> Setup help only <input type="checkbox"/> Supervision <input type="checkbox"/> Limited assistance <input type="checkbox"/> Extensive assistance <input type="checkbox"/> Maximal assistance <input type="checkbox"/> Total dependence <input type="checkbox"/> Activity did not occur	IADL CAPACITY	<input type="checkbox"/> Independent <input type="checkbox"/> Setup help only <input type="checkbox"/> Supervision <input type="checkbox"/> Limited assistance <input type="checkbox"/> Extensive assistance <input type="checkbox"/> Maximal assistance <input type="checkbox"/> Total dependence
b. Ordinary housework —How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)			
IADL PERFORMANCE	<input type="checkbox"/> Independent <input type="checkbox"/> Setup help only <input type="checkbox"/> Supervision <input type="checkbox"/> Limited assistance <input type="checkbox"/> Extensive assistance <input type="checkbox"/> Maximal assistance <input type="checkbox"/> Total dependence <input type="checkbox"/> Activity did not occur	IADL CAPACITY	<input type="checkbox"/> Independent <input type="checkbox"/> Setup help only <input type="checkbox"/> Supervision <input type="checkbox"/> Limited assistance <input type="checkbox"/> Extensive assistance <input type="checkbox"/> Maximal assistance <input type="checkbox"/> Total dependence
c. Managing finances —How bills are paid, checkbook is balanced, household expenses are budgeted, credit card account is monitored			
IADL PERFORMANCE	<input type="checkbox"/> Independent <input type="checkbox"/> Setup help only <input type="checkbox"/> Supervision <input type="checkbox"/> Limited assistance <input type="checkbox"/> Extensive assistance <input type="checkbox"/> Maximal assistance <input type="checkbox"/> Total dependence <input type="checkbox"/> Activity did not occur	IADL CAPACITY	<input type="checkbox"/> Independent <input type="checkbox"/> Setup help only <input type="checkbox"/> Supervision <input type="checkbox"/> Limited assistance <input type="checkbox"/> Extensive assistance <input type="checkbox"/> Maximal assistance <input type="checkbox"/> Total dependence
Comments:			

d. Managing medications —How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)			
IADL PERFORMANCE	<input type="checkbox"/> Independent <input type="checkbox"/> Setup help only <input type="checkbox"/> Supervision <input type="checkbox"/> Limited assistance <input type="checkbox"/> Extensive assistance <input type="checkbox"/> Maximal assistance <input type="checkbox"/> Total dependence <input type="checkbox"/> Activity did not occur	IADL CAPACITY	<input type="checkbox"/> Independent <input type="checkbox"/> Setup help only <input type="checkbox"/> Supervision <input type="checkbox"/> Limited assistance <input type="checkbox"/> Extensive assistance <input type="checkbox"/> Maximal assistance <input type="checkbox"/> Total dependence
e. Phone use —How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)			
IADL PERFORMANCE	<input type="checkbox"/> Independent <input type="checkbox"/> Setup help only <input type="checkbox"/> Supervision <input type="checkbox"/> Limited assistance <input type="checkbox"/> Extensive assistance <input type="checkbox"/> Maximal assistance <input type="checkbox"/> Total dependence <input type="checkbox"/> Activity did not occur	IADL CAPACITY	<input type="checkbox"/> Independent <input type="checkbox"/> Setup help only <input type="checkbox"/> Supervision <input type="checkbox"/> Limited assistance <input type="checkbox"/> Extensive assistance <input type="checkbox"/> Maximal assistance <input type="checkbox"/> Total dependence
f. Shopping —How shopping is performed for food and household items (e.g., selecting items, paying money)—EXCLUDE TRANSPORTATION			
IADL PERFORMANCE	<input type="checkbox"/> Independent <input type="checkbox"/> Setup help only <input type="checkbox"/> Supervision <input type="checkbox"/> Limited assistance <input type="checkbox"/> Extensive assistance <input type="checkbox"/> Maximal assistance <input type="checkbox"/> Total dependence <input type="checkbox"/> Activity did not occur	IADL CAPACITY	<input type="checkbox"/> Independent <input type="checkbox"/> Setup help only <input type="checkbox"/> Supervision <input type="checkbox"/> Limited assistance <input type="checkbox"/> Extensive assistance <input type="checkbox"/> Maximal assistance <input type="checkbox"/> Total dependence
g. Transportation —How travels by public transportation (navigating system, paying fare) or driving self or as a passenger (including getting out of house, into and out of vehicles)			
IADL PERFORMANCE	<input type="checkbox"/> Independent <input type="checkbox"/> Setup help only <input type="checkbox"/> Supervision <input type="checkbox"/> Limited assistance <input type="checkbox"/> Extensive assistance <input type="checkbox"/> Maximal assistance <input type="checkbox"/> Total dependence <input type="checkbox"/> Activity did not occur	IADL CAPACITY	<input type="checkbox"/> Independent <input type="checkbox"/> Setup help only <input type="checkbox"/> Supervision <input type="checkbox"/> Limited assistance <input type="checkbox"/> Extensive assistance <input type="checkbox"/> Maximal assistance <input type="checkbox"/> Total dependence
Comments:			

FUNCTIONAL STATUS	
13. ADL SELF-PERFORMANCE <ul style="list-style-type: none"> Consider all episodes over 3-day period. If all episodes are performed at the same level, score ADL at that level. If any episodes at level 6, and others less dependent, score ADL as a 5. Otherwise, focus on the three most dependent episodes [or all episodes if performed fewer than 3 times]. If most dependent episode is 1, score ADL as 1. If not, score ADL as least dependent of those episodes in range 2-5. Also see decision tree in field guide 	
Independent —No physical assistance, setup, or supervision in any episode Independent, setup help only —Article or device provided or placed within reach, no physical assistance or supervision in any episode Supervision —Oversight / cuing Limited assistance —Guided maneuvering of limbs, physical guidance without taking weight Extensive assistance —Weight-bearing support (including lifting limbs) by 1 helper where person still performs 50% or more of subtasks Maximal assistance —Weight-bearing support (including lifting limbs) by 2+ helpers—OR—Weight-bearing support for more than 50% of subtasks Total dependence —Full performance by others during all episodes Activity did not occur during entire period	
a. Bathing —How takes a full-body bath / shower. Includes how transfers in and out of tub or shower AND how each part of the body is bathed: arms, upper and lower legs, chest, abdomen, perineal area – EXCLUDE WASHING OF BACK AND HAIR	
<input type="checkbox"/> Independent <input type="checkbox"/> Independent, setup help only <input type="checkbox"/> Supervision <input type="checkbox"/> Limited assistance	<input type="checkbox"/> Extensive assistance <input type="checkbox"/> Maximal assistance <input type="checkbox"/> Total dependence <input type="checkbox"/> Activity did not occur during entire period
b. Personal hygiene —How manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands – EXCLUDE BATH AND SHOWERS	
<input type="checkbox"/> Independent <input type="checkbox"/> Independent, setup help only <input type="checkbox"/> Supervision <input type="checkbox"/> Limited assistance	<input type="checkbox"/> Extensive assistance <input type="checkbox"/> Maximal assistance <input type="checkbox"/> Total dependence <input type="checkbox"/> Activity did not occur during entire period
c. Dressing upper body —How dresses and undresses (street clothes, underwear) above the waist, including prostheses, orthotics, fasteners, pullovers, etc.	
<input type="checkbox"/> Independent <input type="checkbox"/> Independent, setup help only <input type="checkbox"/> Supervision <input type="checkbox"/> Limited assistance	<input type="checkbox"/> Extensive assistance <input type="checkbox"/> Maximal assistance <input type="checkbox"/> Total dependence <input type="checkbox"/> Activity did not occur during entire period
d. Dressing lower body —How dresses and undresses (street clothes, underwear) from the waist down including prostheses, orthotics, belts, pants, skirts, shoes, fasteners, etc.	
<input type="checkbox"/> Independent <input type="checkbox"/> Independent, setup help only <input type="checkbox"/> Supervision <input type="checkbox"/> Limited assistance	<input type="checkbox"/> Extensive assistance <input type="checkbox"/> Maximal assistance <input type="checkbox"/> Total dependence <input type="checkbox"/> Activity did not occur during entire period
e. Locomotion —How moves between locations on same floor (walking or wheeling). If in wheelchair, self-sufficiency once in chair	
<input type="checkbox"/> Independent <input type="checkbox"/> Independent, setup help only <input type="checkbox"/> Supervision <input type="checkbox"/> Limited assistance	<input type="checkbox"/> Extensive assistance <input type="checkbox"/> Maximal assistance <input type="checkbox"/> Total dependence <input type="checkbox"/> Activity did not occur during entire period
f. Transfer toilet —How moves on and off toilet or commode	
<input type="checkbox"/> Independent <input type="checkbox"/> Independent, setup help only <input type="checkbox"/> Supervision <input type="checkbox"/> Limited assistance	<input type="checkbox"/> Extensive assistance <input type="checkbox"/> Maximal assistance <input type="checkbox"/> Total dependence <input type="checkbox"/> Activity did not occur during entire period
g. Toilet use —How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes—EXCLUDE TRANSFER ON AND OFF TOILET	
<input type="checkbox"/> Independent <input type="checkbox"/> Independent, setup help only <input type="checkbox"/> Supervision <input type="checkbox"/> Limited assistance	<input type="checkbox"/> Extensive assistance <input type="checkbox"/> Maximal assistance <input type="checkbox"/> Total dependence <input type="checkbox"/> Activity did not occur during entire period
h. Bed mobility —How moves to and from lying position, turns from side to side, and positions body while in bed	
<input type="checkbox"/> Independent <input type="checkbox"/> Independent, setup help only <input type="checkbox"/> Supervision <input type="checkbox"/> Limited assistance	<input type="checkbox"/> Extensive assistance <input type="checkbox"/> Maximal assistance <input type="checkbox"/> Total dependence <input type="checkbox"/> Activity did not occur during entire period
i. Eating —How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)	
<input type="checkbox"/> Independent <input type="checkbox"/> Independent, setup help only <input type="checkbox"/> Supervision <input type="checkbox"/> Limited assistance	<input type="checkbox"/> Extensive assistance <input type="checkbox"/> Maximal assistance <input type="checkbox"/> Total dependence <input type="checkbox"/> Activity did not occur during entire period
j. Transfer – How moves between surfaces including to or from: bed, chair, wheelchairs, standing position. EXCLUDE transfer to/from bath/toilet/vehicle	
<input type="checkbox"/> Independent <input type="checkbox"/> Independent, setup help only <input type="checkbox"/> Supervision <input type="checkbox"/> Limited assistance	<input type="checkbox"/> Extensive assistance <input type="checkbox"/> Maximal assistance <input type="checkbox"/> Total dependence <input type="checkbox"/> Activity did not occur during entire period
Additional assistance needed in any of the following: <input type="checkbox"/> Bathing/Hygiene <input type="checkbox"/> Dressing (upper/lower) <input type="checkbox"/> Locomotion <input type="checkbox"/> Toilet use/Toilet Transfer <input type="checkbox"/> Eating <input type="checkbox"/> Transfer (excluding bath, toilet, or vehicle transfer)	
14. LOCOMOTION/WALKING Primary mode of locomotion <ul style="list-style-type: none"> Walking, no assistive device Walking, uses assistive device—e.g., cane, walker, crutch, pushing wheelchair Wheelchair, scooter Non-ambulatory – e.g., stays in bed, uses gurney 	

<p>15. MOST SEVERE PRESSURE ULCER (Answer ONLY if person uses wheelchair or is non-ambulatory (see item 14) or requires assistance in transfers or bed mobility (see items 13h & 13j).)</p> <p><input type="checkbox"/> No pressure ulcer</p> <p><input type="checkbox"/> Any area of persistent skin redness</p> <p><input type="checkbox"/> Partial loss of skin layers</p> <p><input type="checkbox"/> Deep craters in the skin</p> <p><input type="checkbox"/> Breaks in skin exposing muscle or bone</p> <p><input type="checkbox"/> Not codeable, e.g., necrotic eschar predominant</p>	<p>22. INSTABILITY OF CONDITION</p> <p>a. Conditions/diseases make cognitive, ADL, mood, or behavior patterns unstable (fluctuating, precarious, or deteriorating)</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>b. Experiencing an acute episode, or a flare-up of a recurrent or chronic problem</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>c. End-state disease, 6 or fewer months to live</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>																														
<p>16. EMPLOYMENT STATUS</p> <p><input type="checkbox"/> Employed</p> <p><input type="checkbox"/> Unemployed/retired/student/homemaker, actively seeking employment</p> <p><input type="checkbox"/> Unemployed/retired/student/homemaker, not seeking employment</p> <p><input type="checkbox"/> Unemployed/retired/student/homemaker, but may want to seek employment</p>	<p style="text-align: center;">ENVIRONMENTAL ASSESSMENT</p> <p>23. HOME ENVIRONMENT Code for any of the following that make home environment hazardous or uninhabitable (if temporarily in institution, base assessment on home visit)</p> <p>a. Disrepair of the home—e.g., hazardous clutter; inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors; holes in floor; leaking pipes; broken major appliances</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown</p> <p>b. Squalid conditions—e.g. extremely dirty, infestation by rats or bugs</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown</p> <p>c. Inadequate heating or cooling—e.g., too hot in summer, too cold in winter</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown</p> <p>d. Lack of personal safety—e.g., fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown</p> <p>e. Limited access to home or rooms in home—e.g., difficulty entering or leaving home, unable to climb stairs, difficulty maneuvering within rooms, no railings although needed</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown</p>																														
<p>Who was the primary informant for information on Functional Status? (check one) <input type="checkbox"/> Consumer <input type="checkbox"/> Family/Friend</p> <p><input type="checkbox"/> Legal Guardian/DPOA <input type="checkbox"/> Provider</p>	<p style="text-align: center;">SOCIAL SUPPORTS</p>																														
<p>Which additional informants provided information on Functional Status?(check all that apply) <input type="checkbox"/> Consumer</p> <p><input type="checkbox"/> Family/Friend <input type="checkbox"/> Legal Guardian/DPOA <input type="checkbox"/> Provider</p>	<p>24. TWO KEY INFORMAL HELPERS</p>																														
<p style="text-align: center;">CONTINENCE</p>	<p>a. Relationship to person</p>																														
<p>17. BLADDER CONTINENCE</p> <p><input type="checkbox"/> Continent—Complete control; DOES NOT USE any type of catheter or other urinary collection device</p> <p><input type="checkbox"/> Managed with any catheter or ostomy over the last 3 days</p> <p><input type="checkbox"/> Infrequently incontinent—Not incontinent over last 3 days, but does have incontinent episodes</p> <p><input type="checkbox"/> Occasionally incontinent—Less than daily</p> <p><input type="checkbox"/> Frequently incontinent—Daily, but some control present</p> <p><input type="checkbox"/> Incontinent—No control present</p> <p><input type="checkbox"/> Did not occur—No urine output from bladder in last 3 days</p>	<table border="1" style="width: 100%;"> <thead> <tr> <th style="width: 50%;">Helper 1</th> <th style="width: 50%;">Helper 2</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Child or child-in-law</td> <td><input type="checkbox"/> Child or child-in-law</td> </tr> <tr> <td><input type="checkbox"/> Spouse</td> <td><input type="checkbox"/> Spouse</td> </tr> <tr> <td><input type="checkbox"/> Partner/ sig. other</td> <td><input type="checkbox"/> Partner/ sig. other</td> </tr> <tr> <td><input type="checkbox"/> Parent/ guardian</td> <td><input type="checkbox"/> Parent/ guardian</td> </tr> <tr> <td><input type="checkbox"/> Sibling</td> <td><input type="checkbox"/> Sibling</td> </tr> <tr> <td><input type="checkbox"/> Other relative</td> <td><input type="checkbox"/> Other relative</td> </tr> <tr> <td><input type="checkbox"/> Friend</td> <td><input type="checkbox"/> Friend</td> </tr> <tr> <td><input type="checkbox"/> Neighbor</td> <td><input type="checkbox"/> Neighbor</td> </tr> <tr> <td><input type="checkbox"/> No informal helper</td> <td><input type="checkbox"/> No informal helper</td> </tr> </tbody> </table> <p>b. Lives with person</p> <table border="1" style="width: 100%;"> <thead> <tr> <th style="width: 50%;">Helper 1</th> <th style="width: 50%;">Helper 2</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td><input type="checkbox"/> Yes, 6 months or less</td> <td><input type="checkbox"/> Yes, 6 months or less</td> </tr> <tr> <td><input type="checkbox"/> Yes, more than 6 months</td> <td><input type="checkbox"/> Yes, more than 6 months</td> </tr> <tr> <td><input type="checkbox"/> No informal helper</td> <td><input type="checkbox"/> No informal helper</td> </tr> </tbody> </table>	Helper 1	Helper 2	<input type="checkbox"/> Child or child-in-law	<input type="checkbox"/> Child or child-in-law	<input type="checkbox"/> Spouse	<input type="checkbox"/> Spouse	<input type="checkbox"/> Partner/ sig. other	<input type="checkbox"/> Partner/ sig. other	<input type="checkbox"/> Parent/ guardian	<input type="checkbox"/> Parent/ guardian	<input type="checkbox"/> Sibling	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other relative	<input type="checkbox"/> Other relative	<input type="checkbox"/> Friend	<input type="checkbox"/> Friend	<input type="checkbox"/> Neighbor	<input type="checkbox"/> Neighbor	<input type="checkbox"/> No informal helper	<input type="checkbox"/> No informal helper	Helper 1	Helper 2	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> Yes, 6 months or less	<input type="checkbox"/> Yes, 6 months or less	<input type="checkbox"/> Yes, more than 6 months	<input type="checkbox"/> Yes, more than 6 months	<input type="checkbox"/> No informal helper	<input type="checkbox"/> No informal helper
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<p>18. BOWEL CONTINENCE</p> <p><input type="checkbox"/> Continent—Complete control; DOES NOT USE any type of ostomy device</p> <p><input type="checkbox"/> Control with ostomy—Control with ostomy device over last 3 days</p> <p><input type="checkbox"/> Infrequently incontinent—Not incontinent over last 3 days</p> <p><input type="checkbox"/> Occasionally incontinent—Less than daily</p> <p><input type="checkbox"/> Frequently incontinent—Daily, but some control present</p> <p><input type="checkbox"/> Incontinent—No control present</p> <p><input type="checkbox"/> Did not occur—No bowel movement in the last 3 days</p>	<p>25. INFORMAL HELPER STATUS</p> <p>a. Informal helper(s) is unable to continue in caring activities—e.g., decline in health or work/school obligations makes it difficult for helper to continue</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No informal helper</p> <p>b. Primary informal helper expresses feelings of distress, anger, or depression</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No informal helper</p> <p>c. Family or close friends report feeling overwhelmed by person's needs</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No informal helper</p>																														
<p>19. BLADDER MANAGEABILITY, in current setting</p> <p><input type="checkbox"/> Yes (well managed) <input type="checkbox"/> No (not well managed)</p>																															
<p>20. BOWEL MANAGEABILITY, in current setting</p> <p><input type="checkbox"/> Yes (well managed) <input type="checkbox"/> No (not well managed)</p>																															
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<p>Which additional informants provided information on Continence?(check all that apply) <input type="checkbox"/> Consumer <input type="checkbox"/> Family/Friend</p> <p><input type="checkbox"/> Legal Guardian/DPOA <input type="checkbox"/> Provider</p>																															
<p style="text-align: center;">HEALTH CONDITIONS</p>																															
<p>21. FALLS</p>																															
<p>a. In last 30 days <input type="checkbox"/> No falls <input type="checkbox"/> One fall <input type="checkbox"/> Two or more falls</p>																															
<p>b. 31-90 days ago <input type="checkbox"/> No falls <input type="checkbox"/> One fall <input type="checkbox"/> Two or more falls</p>																															
<p>c. 91-180 days ago <input type="checkbox"/> No falls <input type="checkbox"/> One fall <input type="checkbox"/> Two or more falls</p>																															

SECTION IV. SERVICES RECOMMENDED	
CARE Consumers only. Not required for HCBS-FE, PD, TBI, PACE, TBIRF assessment.	
These services are identified as those that could enable the consumer to remain in community settings.	
Code Definitions (If service not recommended, leave blank):	
0. Assessor does not know if available	
1. Service is available	
2. Service available but waiting list	
3. Service available but consumer does not have resources to pay	
4. Service is not available	
5. Service available but consumer chooses to not use	
6. Service does not exist	
ADL Services	
ASTE-Assistive Technology	
ATCR-Attendant Care (personal or medical)	
BATH-Bathroom (items)	
INCN-Incontinence supplies	
PHTP-Physical Therapy	
MOBL-Mobility/Aids/Assistive Technology/Custom Care	
IADL Services	
CHOR-Chore	
CMEL-Congregate Meals	
HHSER-Home Health Services	
HMEL-Home Delivered Meals	
HMKR-Homemaker	
MEDIC-Medication Issues	
FMGT-Money/Financial Management Assistance	
MMEG-Medication Management Education	
NCOU-Nutrition Counseling	
SHOP-Shopping	
TPHN-Telephoning	
TRNS-Transportation	
Other Services	
ANEKDADS-Abuse/Neglect/Exploit. Investigation - Facility	
ANESRS - Abuse/Neglect/Exploit. Investigation - Community	
ADCR-Adult Daycare	
ALZH-Alzheimer Support Service	
CMGT-Case Management	
CNSL-Counseling	
HOUS-Community Housing/Residential Care	
HOSP-Hospice	
INAS-Information & Assistance	
LGLA-Legal Assistance	
MASC – Sleep Cycle Support	
NRSN-Nursing/Short Term Skilled/Part Time/Inpatient	
OCCT-Occupational Therapy	
PAPD-Prevention of Depression Activities	
PEMRI-Personal Emergency Response System	
RESP-Respite Care	
RMNR-Repairs/Maintenance/Renovation	
SENS-Sensory Aids	
SLPT-Speech & Language Therapy	
VIST-Visiting	
OTEM: Other:	

Additional Resources/Needs	
ALVG-Assisted Living Facility	
EMPL-Employment	
GUAR-Guardianship/Conservator	
CAG – Caregiver Training	
MCID-Medicaid Eligibility	
VBEN-Veterans	
HINJS-Home Injury Control Screening	
ADRC – Aging and Disability Resource Center	
AAA – Area Agency on Aging	
CMHC-Community Mental Health Center	
CDDO-Community Developmental Disabilities Organization	
CILS-Center for Independent Living Services	
RPCC-Regional Prevention Center Contacts	
Service Comments:	